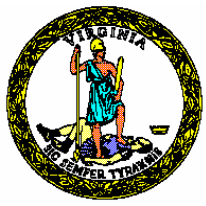

COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

May 25, 2005

Dear Prospective Vendor:

The Department of Medical Assistance Services (DMAS) is soliciting proposals from qualified firms for a Virginia Disease Management (DM) Program Administrator. Duties of the contractor will include providing outreach and education on the DM program, performing an initial assessment, counseling and regularly assessing all program participants, and maintaining a 24-hour toll-free nurse call line for all program participants. The contractor will also monitor clinical health outcome measures and track changes in Virginia's Medicaid and State Children Health Insurance Program (known as "FAMIS") expenditures for participants in the DM program. The selected Contractor will provide the required services for DMAS. Specific details about this procurement are in the enclosed Request for Proposal (RFP) 2005-06. Contractors must check the DMAS web site at www.dmas.virginia.gov or check the eVA web site at www.eva.state.va.us for any addendums or notices regarding this RFP.

The Commonwealth will not pay any costs that any Contractor incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Contractors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Karen Lawson, Senior Policy Analyst, Policy and Research Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to dsm@dmas.virginia.gov.

Sincerely,

Christopher M. Banaszak

Christopher M. Banaszak
Contract Officer

Enclosure

REQUEST FOR PROPOSALS
RFP 2005-06

Issue Date: May 25, 2005

Title: Virginia Medicaid/FAMIS Disease Management Program Administrator

Period of Contract: An initial period of three years from award of contract, with provisions for two twelve-month extensions.

All inquiries should be directed in writing via email in MS Word Format to: dsm@dmas.virginia.gov

Karen Lawson
Senior Policy Analyst
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Deadline for submitting inquiries is 2:00 pm E.S.T., June 8, 2005

Proposal Due Date: Proposals will be accepted until 2:00 p.m. E.S.T. on June 27, 2005

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

"RFP 2005-06 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: Chris Banaszak

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone	Date Signed
Fax Number	
eVA Registration Required	eVA Vendor #:
Check Applicable Status Corporation ---------- Partnership --------- Proprietorship -------- Individual ------Woman Owned ---------- Minority Owned ---------- Small Business ---------	

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

VIRGINIA MEDICAID/FAMIS
DISEASE MANAGEMENT PROGRAM ADMINISTRATOR

RFP 2005-06

ISSUED May 25, 2005

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RFP 2005-06 Virginia Disease Management Program Administrator

1. PURPOSE AND DEFINITIONS

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the *Social Security Act* and the Virginia State Child Health Insurance Program, known as the Family Access to Medical Insurance Security (FAMIS), under Title XXI of the *Social Security Act* for low-income people. These programs are financed by federal and state funds and administered by the state according to federal guidelines. Both programs include coverage of medical services for eligible Medicaid and FAMIS enrollees.

DMAS provides Medicaid to individuals through three programs: MEDALLION, a Primary Care Case Management (PCCM) program utilizing contracted primary care providers; Medallion II, a program utilizing contracted managed care organizations (MCO); and Fee-for-Service (FFS), the standard Medicaid program. Individuals who receive home and community-based waiver (HCBW) services are in the FFS program. Additional information on HCBW services can be found in Attachment I. Although FAMIS is not a Medicaid program, it is provided through the FFS, PCCM, and MCO delivery systems.

The DMAS managed care programs primarily serve four groups: FAMIS Plus (Medicaid children), FAMIS, pregnant women, and individuals who receive Supplemental Security Insurance. Approximately 2,000 primary care providers are enrolled in MEDALLION, and seven MCOs participate in Medallion II and FAMIS. Approximately 103 Virginia localities have MCOs. Attachment II provides a detailed description of areas covered by managed care programs and MCO characteristics.

Effective April 2005, enrollment for each is as follows:

Fee For Service	238,907	(Approximately 15,784 received HCBW services)
MEDALLION	88,104	
Medallion II	335,615	

The 2004-2006 Appropriation Act, Item 326, #AAAA (see Attachment III) provides the Department the authority to develop a disease management program for Medicaid and FAMIS fee-for-service (FFS) enrollees. Therefore, the Department is hereby soliciting proposals from qualified organizations through a competitive procurement process for a disease management program administrator (DMPA) to include certain Medicaid and FAMIS FFS and MEDALLION enrollees. This Request for Proposals (RFP) is for the provision of Disease Management services statewide or in specified geographic locations for Medicaid and FAMIS enrollees diagnosed with asthma, coronary artery disease (CAD), congestive heart failure (CHF), and/or diabetes.

A Disease Management Program Administrator (DMPA) is being sought in an effort to meet the following overall objectives:

- Identification, evaluation, and management of disease state(s) specified in the contract as well as all co-morbid conditions of all participants included in the project;
- Adherence to national evidence-based disease management practice guidelines, in order to improve participant's health status;

- Integration of preventive care into the clinical management model;
- Overall reduction of acute medical expenditures, on average, for the population of participants served;
- Reduction in hospital admissions and non-emergent emergency department use;
- Coordination and reduction of unnecessary or inappropriate medication;
- Increased participant and provider education and participant self-management skills;
- Measured indication of participant and provider satisfaction with program;
- Coordination of participant care including establishment of coordination between providers, the participant, and the community; and
- Regular reporting of clinical outcome measures, profiles of participants and providers, and Medicaid/FAMIS health care expenditures of participants.

The Contractor shall perform all services under this RFP. The Contractor shall comply with all applicable administrative rules and the Department's written policies and procedures, as may be amended from time to time. Copies of such rules and policies are available from the Department.

Duration of Contract: The duration of the contract resulting from this RFP is three years from implementation, with up to two one-year renewals at the Department's option.

General Scope of Responsibilities: The responsibilities of the Disease Management Program Administrator (DMPA), which are more fully described later in the RFP, include providing outreach and education on the DM program, performing an initial assessment, counseling and regularly assessing program participants, and maintaining a 24-hour toll-free nurse call line for all program participants. The contractor will also monitor clinical health outcome measures and track changes in health care expenditures for participants in the DM program. The Contractor(s) selected in response to this RFP must be able to perform the services described in the RFP's Section 4 Technical Proposal Requirements by November 1, 2005.

Number of Awards: Based on the proposals, DMAS is planning to select and enter into a contractual agreement with one or more qualified organization(s) for the provision of disease management (DM) administration services in the Commonwealth. The program will include all Medicaid and FAMIS enrollees with the exception of:

- Individuals enrolled in Medicaid/FAMIS managed care organizations;
- Individuals enrolled in Medicare (dual eligibles);
- Individuals who live in institutional settings (such as nursing homes); and
- Individuals who have third party insurance.

Targeted Conditions

Interested Offerors may offer a program for Disease Management (DM) eligibles identified with the following targeted conditions:

- Asthma
- Diabetes
- CAD
- CHF

Interested offerors may also target Pediatric Diabetes and/or Asthma as an exclusive DM program through a separate proposal. Offerors that propose a DM program that targets multiple conditions and covers DM eligibles statewide will be given priority consideration.

- If an Offeror is unable to propose a statewide DM Program, the Offeror must include a written explanation as to why it is not feasible to produce a statewide program and specify which geographic area, or "region", will be targeted for the DM Program. The region must be large enough to encompass a sufficient number of potential DM eligibles to sustain their operations.

The Department will award contracts in a manner that does not allow programs to overlap with another, similar contracted program within the same region. The Department will award contracts based on the criteria and process described in Sections 3 and 4 of the RFP.

Volume and Participation

Attachment IV of this RFP identifies the potential number of Medicaid and FAMIS enrollees with specific chronic conditions for Calendar Year 2004 and their expenditures. The data is also broken down by region, age range, and provides data on those with co-morbidities. Attachment V provides a breakdown of each managed care region.

The proposed DM program outlined in this RFP will initially be voluntary ("opt-in") for program participants; however, the Department will be pursuing federal approval to change the DM program into a mandatory, or "opt-out" model. Any technical contract modifications will be made at the time federal approval is received to operate a mandatory DM program. Offerors that respond to the RFP need to discuss in their proposal how they plan to address transitioning from a voluntary to a mandatory program.

Virginia is currently in the process of expanding the availability of managed care for Medicaid recipients. Currently, managed care through the Managed Care (MCO) program is only available in certain regions of the state. Through the MCO program, Virginia pays private managed care organizations a per member per month fee through a full risk contract to manage all of the recipients' care. All reimbursement and claims processing is negotiated and completed by the managed care organization for the recipient. As the MCO program expands, the MEDALLION program will be reduced, and in some cases, eliminated.

Medicaid eligibles who are in MEDALLION will be included in the contract for a disease management program. However, those enrolled in the MCO program are excluded. Therefore, as Medallion II expands, the number of eligible persons for disease state management will decrease.

The following major expansions in the MCO program are planned in the next year:

- Region 6 will be expanded in Summer 2005 and MEDALLION & FAMIS will be eliminated;
- Region 7 will be implemented in December 2005 and MEDALLION & FAMIS will be eliminated; and
- Region 4 will be implemented in May 2006 and MEDALLION & FAMIS will be eliminated.

Attachment IV identifies the number of Medicaid recipients who will be affected by this change. The Department will provide the Contractor with 60 days notice prior to the expansion.

1.2 Definitions

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

1. Administrative Cost - All costs to the Contractor related to the administration of this RFP. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP (including, but not limited to, postage, personnel, rent) are considered to be an "administrative cost."
2. Administrative Services Fee - The per member per month amount the Contractor will be paid by the Department for provision of the services outlined in this RFP.
3. Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
4. Assessment - The gathering of specific information about the participant's condition and evaluation of the participant's knowledge and understanding of his/her condition in order to determine the specific educational needs of the participant and to recommend an appropriate intervention plan.
5. Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.
6. Care Management – The practice of managing or supervising the management of the participant. Coordination of care includes an initial clinical assessment and development and evaluation of participant goals in the DM program, condition-specific education of participants and providers as needed, conducting routine monitoring of the participants condition; physician interaction and referrals to additional ancillary services, as needed.
7. CAP – Means corrective action plan.
8. CMS - Centers for Medicare and Medicaid Services.
9. Comorbid Condition – A condition that is secondary to, and often related to, the primary condition (asthma, congestive heart failure, coronary artery disease, and diabetes).
10. Contract - The signed and executed document resulting from this RFP.
11. Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.
12. Contractor/Offeror - See Disease Management Program Administrator (DMPA).
13. Covered Service - Disease management services for Medicaid or FAMIS fee-for-service enrollees as described in Sections 4 and Attachment I of this RFP. This does not include the provision of medical services.
14. Department - The Virginia Department of Medical Assistance Services.
15. Disease Management (DM)-Eligible – An individual who is a non-excluded Medicaid or FAMIS fee-for-service enrollee who is identified by the Contractor as a candidate for enrollment into the DM program.
16. Disease Management Program Administrator (DMPA) - An entity that contracts with the Department of Medical Assistance Services to manage or direct a disease management (DM) program on behalf of the Department. For the purposes of this RFP and resulting contract, the

DMPA is responsible to the Contractor for administering the Department's DM program statewide (or in specific geographic locations, depending on the contract) for Title XIX Medicaid and Title XXI FAMIS or FAMIS Plus fee-for service recipients to include coordination and management of such DM services.

17. Disenrollment - The discontinuance of an enrollee's eligibility to receive covered services under the terms of this RFP.
18. Encryption – A security measure process involving the conversion of data into a format that cannot be interpreted by outside parties.
19. Enrollment - The process by which the contractor notifies a Medicaid or FAMIS enrollee of eligibility for the DM program, receives permission from the Medicaid or FAMIS enrollee to enroll, and enters the Medicaid or FAMIS enrollee into its database for disease management services.
20. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this RFP; or (b) maintained by a subcontractor to provide services on behalf of the Contractor.
21. FAMIS Enrollee - A person enrolled in the Department's State Children Health Insurance Program (FAMIS or FAMIS Plus program) who is identified by the Department as being eligible for DM services due to enrollment in fee-for-service FAMIS or FAMIS Plus. The contractor(s) will be responsible for determining whether the DM-eligible persons have the relevant disease states that would allow their enrollment into the DM program.
22. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment amounts for defined services.
23. Fiscal Year (State) – July 1 through June 30.
24. Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.
25. Grievance – An expression of dissatisfaction by the enrollee about any action taken by the Contractor or service provider.
26. Health Care Expenditures – For the purposes of this RFP, health care expenditures include inpatient hospital, outpatient hospital, physician, pharmacy, and lab and x-ray expenditures for Medicaid and FAMIS enrollees.
27. Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
28. Home and Community-Based Waiver Services means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to individuals who would otherwise require the level of care provided in an institutional setting. Virginia currently offers five waiver programs.
29. Inquiry – An oral or written communication by or on the behalf of an enrollee to the Contractor that may be: 1) questions regarding the need for additional information about benefits, plan requirements or materials received, etc.; 2) provision of information regarding a change in the enrollee's status such as address, family composition, etc.; or 3) a request for assistance such as obtaining translation services, etc. Inquiries are not expressions of dissatisfaction.
30. Managed Care Organization - An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion II and FAMIS programs.

31. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to utilize the services included in the DM program and to be aware of the services offered by the Contractor pursuant to this RFP.
32. MEDALLION – Virginia's Medicaid Primary Care Case Management (PCCM) program that utilizes contracted primary care providers.
33. Medicaid enrollee- Any person identified by the Department as being eligible for DM services due to enrollment in fee-for-service Medicaid (with the exception of those enrolled in Medicare (dual eligibles), those in institutions, and those with third party insurance coverage). The contractor(s) will be responsible for determining whether the DM-eligible persons have the relevant disease states that would allow their enrollment into the DM program.
34. Member - See participant.
35. Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.
36. Net Savings – The percent difference between the expected per member per month health care expenditures for services in the program year (calculated using the predictive modeling methodology approved by the Department) and the actual per member per month health care expenditures, less program costs observed in the program year.
37. Participant - A Medicaid or FAMIS enrollee who has been identified as a DM eligible who is actively receiving care management services in the DM program.
38. Participation Rate: Measure of participation in the disease management program among the identified DM eligibles.
39. Predictive Model – The methodology approved by the Department for developing the expected per member per month health care expenditures for the program year to be used in the calculation of net savings.
40. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.
41. Primary Care Provider - A primary care physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
42. Primary Condition – The principal condition for which a case is managed. Conditions are identified and assigned by a review of medical and pharmacy claims during the identification and stratification process.
43. Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.
44. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Department.
45. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with

established guidelines and standards and reflective of the current state of disease management knowledge.

46. Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
47. Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.
48. Recipient – See Medicaid enrollee, FAMIS enrollee.
49. Referral – A request by a PCP for a participant to be evaluated and/or treated by a different physician, usually a specialist.
50. Semi-annually – For the purposes of contract reporting requirements, semi-annually shall be defined as within 30 calendar days after the end of a six-month period, unless otherwise specified by the Department.
51. Services - See covered service.
52. Shall - Indicates a mandatory requirement or a condition to be met.
53. State - Commonwealth of Virginia.
54. State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted by the Department to CMS for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-325, as amended.
55. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP.
56. Subcontractor - Any State approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP.
57. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.

2. BACKGROUND

A disease management program is an integrated, systematic health care management approach to improve participant outcomes and lower medical costs for participants living with specific chronic health conditions.

Due to unprecedented budget deficits fueled in part by nearly double-digit growth in the Medicaid program, Virginia, like many other states, is grappling with ways to control health care spending for the poor. Medicaid expenditure data consistently show that a disproportionate amount of spending in Virginia's program can be attributed to recipients with certain chronic diseases. Accordingly, policymakers have given considerable attention to the concept of disease management as a means of improving health outcomes for program beneficiaries while concomitantly slowing the growth in Medicaid spending.

Virginia has a history of providing disease management services through its managed care organization program, Medallion II, which began in 1996. Medicaid managed care organizations (MCOs), as part of their internal quality improvement program, have systems in place that ensure coordinated patient care for all enrollees and that provide particular attention to the needs of Medicaid and FAMIS enrollees with complex, serious and/or disabling conditions. Also, since MCOs are paid a per member per month capitated rate, it is in the best interest of MCOs to use disease management services to control costs.

In contrast to Medicaid managed care, the Medicaid and FAMIS fee-for-service populations have not had consistent access to disease management services. Virginia first piloted the concept of disease management (DM) for this population in 1993 when DMAS targeted Medicaid recipients who were enrolled in the MEDALLION primary care case management program. Known as the Virginia Health Outcomes Partnership (VHOP), this program focused primarily on educating primary care physicians in the MEDALLION program who were treating persons with asthma. While the outcomes reported for the program were favorable, the administrative cost of the demonstration was significant, and the methods used to estimate the return on investment for this pilot program were not reliable. In 1997, DMAS expanded the DM program statewide but changed the program model used for VHOP and substantially increased the number of disease states for the project. An evaluation conducted at the end of the VHOP program by Heritage estimated a rate of return of $1.75 for every dollar spent.

Attachment VI identifies health care expenditures for FFS Medicaid and FAMIS enrollees who have asthma, coronary artery disease, congestive heart failure, and diabetes.

Under the direction of the 2002-2004 Appropriation Act, DMAS pursued the development of a statewide DM program by issuing a RFP in 2002. The proposed program was projected to cost $1.4 million with assumed savings of $22 million – a rate of return of 16 to 1. DMAS was, however, unable to find a vendor to operate a DSM program for $1.4 million and, for this and other reasons, was subsequently forced to withdraw the RFP for this project in the spring of 2003.

In 2004, DMAS was approached by Anthem Health Plan, which offered to operate a pilot DM program at no cost for Virginia Medicaid participants. The pilot program, titled *Healthy Returns*SM, targets certain Medicaid fee-for-service participants who have coronary artery disease and congestive heart failure. *Healthy Returns*SM, which began on June 1, 2004, had 2,468 active participants as of December 2004. Preliminary results show clinical improvement of the health outcomes of program participants, however cost savings resulting from the program were not available at the time this RFP was written.

A key goal of the Department is to assure the delivery of preventive care, promotion of self-management and appropriate use of medical services in the fee-for-service system. Participants with chronic illnesses often present a challenge to health delivery systems through their multiple referral patterns and associated high costs. Chronic illnesses are treatable and with prompt intervention, emphasis on preventive self-management and on going case management, mortality and morbidity can be reduced.

2.1 Budget Amendment to the 2004-2006 Appropriation Act

The 2005 General Assembly amended the 2004-2006 Appropriation Act (see Attachment I) to authorize the Department of Medical Assistance Services to outsource the administration of a program to provide disease state and chronic care management services for Medicaid recipients to an administrative services

contractor. In addition, the Act provides that the Department shall have the authority to amend the State Plan as necessary for Title XIX (Medical Assistance) of the Social Security Act within 280 days or less from the enactment of the Act to provide disease management services to individuals enrolled in these programs.

3. NATURE AND SCOPE OF SERVICES

The most significant responsibility of the Contractor will be the development, implementation, and evaluation of a disease management (DM) program for Medicaid and FAMIS fee-for-service enrollees, including the development of outreach campaigns for enrollees and providers. Currently, there is only a pilot program (Anthem's *Healthy Returns*SM)) available for a select number of these enrollees that will end prior to the start of a contracted DM program.

The proposed DM program outlined in this RFP will initially be voluntary ("opt-in") for program participants; however, the Department will be pursuing federal approval to change the DM program into a mandatory, or "opt-out" model. Any technical contract modifications will be made at the time federal approval is received to operate a mandatory DM program. Offerors that respond to the RFP need to discuss in their proposal how they plan to perform tasks outlined in this RFP within a voluntary and a mandatory program.

DMAS will provide to the Contractor, on a monthly basis, eligibility files and health expenditure claims for Medicaid or FAMIS enrollees. From the claims data the Contractor will identify Medicaid or FAMIS enrollees with the conditions identified in its contract ("DM-eligibles") with the Department. Tasks to be performed by the Contractor are outlined below.

3.1 Tasks

The following tasks are the services expected of the Contractor. Contractors are encouraged to be creative in how these tasks are accomplished. Contractors may add additional tasks in their proposal or suggest an alternate task to replace a task described below and how the alternate task will meet the same objective as appropriate (and as approved by the Department). Technical requirements related to each of these tasks may be found in Section 4 of this RFP.

The Contractor shall not provide medical services to DM participants as a part of the DM program.

3.1.1 Identify persons with the relevant disease states (DM-eligibles) from the eligibility and claims data on non-excluded Medicaid and FAMIS enrollees provided by the Department. If the Contractor plans on using a risk stratification system, this needs to be explained in the proposal.

3.1.2 Contact DM-eligibles and inform them of the availability of the DM program. If the DM-eligible chooses to participate (in the voluntary program), enroll the DM-eligible into the DM program. If the DM program is mandatory, automatically enroll the DM-eligible. Monitor enrollment of DM-eligible individuals into the DM program, instances of participant refusal to participate, and the disenrollment of participants from DM program services. The Contractor will be expected to report this information to the Department as specified in Section 4.14.

3.1.3 Provide care management of program participants consistent with national evidence-based guidelines (HEDIS® measures) for the targeted conditions. At a minimum, care management must include:

- Conducting a baseline health status assessment of the participant's health and physical needs;
- Providing routine participant contact to monitor the participant's health status which may be based on the severity of the participant's health status and assessment;
- Providing education to participants on specific health needs and self-management activities;
- Monitoring participant compliance with self-management protocols; and
- Facilitating participant contact with providers and community agencies when necessary to support the participant (to include referrals).

Contractors have the flexibility to describe in their proposal how care management will be provided. Examples of care management include, but are not limited to: use of case managers to make regular phone calls or face to face visits to assess participant's health status; and use of electronic media devices to communicate health status with participants.

In addition, Contractors will need to describe in their proposal how they plan to manage participants who:

- Are functionally/cognitively incapable of assisting in their treatment plan, or attaining self-management objectives;
- Are children with special health needs, or are participants with severe mental illness or substance abuse issues, especially in areas with limited community resources;
- Are homeless or who do not have phones.

3.1.4 Provide clinical support to answer medical questions for DM program participants 24 hours per day, 7 days per week through a centralized toll-free Nurse Line. Requirements for the Nurse Line are specified in Section 4 of this RFP.

3.1.5 Utilize national evidence-based guidelines for the conditions specified in the Contractor's DM program. This includes the use of HEDIS® measures specified in Attachment VIII in disseminating treatment protocols to participants and providers and in educating providers.

3.1.6 Provide periodic reports to the Department as specified in Section 4 of this RFP.

3.1.7 Monitor participant satisfaction associated with DM programs through participant surveys and complaint processes.

3.1.8 Establish and Increase participation in DM programs by DM-eligibles.

3.1.9 Provide an additional local or toll-free telephone line with the approval of the Department to handle incoming phone calls from providers, program participants, or interested parties that have questions about the DM program.

3.1.10 Work closely and cooperatively with entities, including but not limited to community services organizations, advocacy groups, Medicaid and private providers, schools, health departments,

local departments of social services, family members, and other interested parties, when such parties are working on behalf of the participant in relation to services received by the participant in the DM program.

3.1.11 The Offeror's response shall comply with HIPAA confidentiality requirements, and at a minimum shall include following up with the participant or the participant's responsible party regarding the issue/need communicated by the interested party.

DMAS welcomes new and innovative approaches to DM program services. While fully addressing the DMPA objectives on Pages 8-9 of this RFP, the Offeror may also include alternate approaches for DMAS' consideration.

These tasks may be refined by DMAS and the selected Offeror(s) during negotiations, and will be included in the final resulting Contract.

3.1 Mandatory Program Specifications

The following areas have been determined as technical mandatory requirements for the program. The successful Offeror must be able to meet each of the following requirements. Offerors will indicate their understanding and ability to perform these tasks in their Technical Proposal to the Department:

1. Demonstrate via the Offeror's references and statement of work a minimum of three (3) years of disease management experience with clients of comparable size (defined as the number of anticipated participants) or patient mix. At least one (1) of the required 3 years must be Medicaid or related health care specific experience.

2. The Offeror's Disease Management Program must be accredited and/or certified by the National Committee Quality and Accreditation (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the American Accreditation HealthCare Commission (URAC). Copies of the Offeror's accreditation and/or certification must be submitted with the Technical Proposal. If the Offeror currently does not have accreditation or certification from one of these organizations, the Offeror must state in its proposal that accreditation or certification by NCQA, JCAHO, or URAC will be achieved within 18 months of contract award. Contractors that do not achieve accreditation or certification within this time period will be subject to the application of sanctions as provided in Attachment VI of this RFP.

4. TECHNICAL PROPOSAL REQUIREMENTS

This section contains the technical proposal requirements for this RFP. The Offeror shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and by cross-referencing the Offeror's proposal response to each RFP requirement. The narrative shall demonstrate that the Offeror has considered all the requirements and has developed a specific approach to meeting them in order to implement a successful project. It is not sufficient to state that the requirements will be met. The description shall correspond to the order of the tasks described herein.

The Offeror may perform all of these processes internally or involve subcontractors for any portion. Subcontractors shall be identified by name and by a description of the services/functions they will be

performing. The Contractor shall be wholly responsible for the performance of this entire contract whether or not subcontractors are used.

The Contractor that obtains the contract to provide a DM program that includes coronary artery disease and congestive heart failure shall make maximum efforts to ensure minimum disruption in services to those enrolled in the current pilot program and make any system changes necessary to transfer information without material disruption during implementation phase of the program.

4.1 Enrollment and Claims

4.1.1 Enrollment and Claims Data

The Department is responsible for the enrollment of Medicaid and FAMIS enrollees into the Medicaid and FAMIS Programs. It will be the Contractor's responsibility to identify DM-eligibles with data provided by the Department, provide outreach to the DM-eligibles, and enroll DM-eligibles into the Contractor's DM program. The Offeror must include with its response to this RFP how it plans to enroll DM-eligibles.

At the start of the program, the Contractor shall receive two years of health care expenditure claims and eligibility enrollment data (including contact information) for Medicaid and FAMIS enrollees. Once a month thereafter, the Department shall provide updated Medicaid and FAMIS enrollee eligibility data and the previous month's claims history. The Contractor will receive the data from the Department as described in Section 4.12. Prior to the transfer of protected health information, the Department and the Contractor shall enter into a DMAS Business Associate Agreement to ensure compliance with HIPAA.

4.1.2 Disenrollment

The Department is responsible for the disenrollment of Medicaid and FAMIS enrollees from the Medicaid and FAMIS programs; the Contractor is responsible for disenrolling DM participants from the DM program. The Contractor may disenroll a participant for the following reasons:

- At the participant's request;
- By notification by the Department that the individual is no longer eligible for the Medicaid or FAMIS program; or
- If the participant becomes a dual eligible, enters managed care or an institutional setting, or gets third party liability.

If the contractor wants to disenroll participants for additional reasons, these reasons must be stated in the proposal. The Contractor shall not be able to grieve Medicaid or FAMIS disenrollment actions taken by the Department.

It will be the Contractor's responsibility to include with its response to the RFP how it plans to disenroll a participant from the DM program. This response should also include how the Contractor will handle participants who are disenrolled (i.e., they transition to managed care) The Contractor should also include how it will handle participants who are disenrolled on a temporary basis (i.e., they lose Medicaid eligibility for two months) or and how the Contractor will ensure continuity of DM program services during this time.

4.1.3 Disease Management Care Outside of Eligibility and DM Program Effective Dates

Except where required by this Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor shall not provide DM services prior to the effective date the Medicaid or FAMIS enrollee chooses to participate in the DM program with the Contractor. Additionally, the Contractor shall not provide DM services beyond the month the Contractor is notified by the Department that the recipient is no longer eligible for Medicaid or FAMIS or if the participant requests to disenroll from the DM program.

4.2 Enrollee Materials and Communications

The Contractor shall design, produce and distribute various types of enrollee materials, including but not limited to brochures, provider directories, fact sheets, notices, or any other material necessary to provide information to enrollees as agreed upon and required by the Contract resulting from this RFP, and shall bear all costs related to this activity. In response to this RFP, the Contractor must submit as examples copies of materials utilized in contracts of a similar scale to address the requirements outlined in this RFP.

The Contractor may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. Any costs of additional services provided above the base requirements must be listed separately in the Offeror's Cost Proposal. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by the Department prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements of this RFP. Letters sent to enrollees in response to an individual query do not require prior approval. The required enrollee materials include the following:

4.2.1 DM-Eligibles Information

The Offeror must include with its response to this RFP how it plans to educate DM-eligibles about the DM program and how the Offeror will disseminate such information to DM-eligibles. DM-eligibles must be notified within 30 days of identification by the Contractor that they are eligible for DM program services.

DM-eligible materials shall, at a minimum, be in accordance with all applicable requirements described in this RFP. The DM-eligible materials shall include information about DM services for DM-eligibles and a clear statement that these services are available at no cost and without cost sharing responsibilities. Additionally, the material must list the toll-free Nurse Line number (or another number, if the Contractor specifies) for the Contractor with a statement that the DM-eligible may contact the plan regarding questions about their care under the program.

4.2.2 Prior-Approval Process for DM-Enrollee/Participant Materials

The Contractor shall submit a detailed description of any materials it intends to use and a description of any activities prior to implementation or use. This includes, but is not limited to, all policies (including confidentiality) and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, letters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.

All materials submitted by the Contractor shall be accompanied by a plan that describes the Contractor's intent and procedure for the use of the materials. All written materials submitted by the Contractor must be submitted on paper and in electronic file media. Materials developed by a recognized entity having no association with the Contractor that are related to disease management must be submitted for approval; however, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to the Department. Electronic files submitted in any other format than those approved by the Department shall not be processed.

The Department shall review the Contractor's materials and approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission. Once the Department has approved the materials, the Contractor shall submit one (1) electronic copy of the final product to the Department's Disease Management Contract Monitor. Some problems may not be evident from the materials submitted, but may become apparent upon use. The Department reserves the right to notify the Contractor to discontinue or modify materials, or activities after approval.

4.2.3 Written Material Guidelines

- All materials shall be worded at a 6th grade reading level, unless the Department approves otherwise.
- All written materials shall be clearly legible with a minimum font size of 12 pt. unless otherwise approved by the Department.
- All written materials shall be printed with an assurance of non-discrimination.
- The Seal of the Commonwealth of Virginia shall not be used on communication material without the written approval of the Department.
- All documents and enrollee materials must be translated and available in Spanish. Within ninety (90) days of notification from the Department all vital documents must be translated and available to each Limited English Proficiency group identified by the Department that constitutes five percent (5%) or more of the DM program population.
- All written materials shall be made available in alternative formats upon request by persons with special needs and appropriate interpretation services shall be provided by the Contractor.
- The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees. The Contractor shall provide written notice at least thirty (30) days before the effective date of the change.
- The cost of design, printing, and distribution (including postage) of all enrollee materials shall be borne by the Contractor. The Contractor shall comply with all Federal postal regulations and requirements for the mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and at no expense to the Department.

4.2.4 Failure to Comply with Enrollee Material and Communication Requirements

All DM materials must adhere to the requirements as described. Failure to comply with the communication limitations/standards contained in this RFP, including but not limited to the use of unapproved and/or disapproved processes and communication materials, may result in the imposition by the Department of

one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

i. Revocation of previously authorized communication methods;
ii. Application of sanctions as provided in Attachment VI of this RFP.

4.3 Telephone Toll-Free Nurse Line

The Contractor shall provide and maintain at least one toll-free telephone Nurse Line, with a unique and dedicated toll-free telephone number, for providers and program participants. The Nurse Line shall be available seven days per week, 24 hours per day.

If the contract is for a statewide DM program, the Contractor shall provide an additional toll-free telephone call line (or a local telephone call line, if the contract is for a specific geographic location) with the approval of the Department to handle incoming phone calls from providers, program participants, or interested parties that have questions about the DM program or questions that are not health related.

Estimation of Call Volume: Based on experience with the *Healthy Returns*SM pilot DM program for individuals with CHF and CAD, DMAS estimates there will be a six percent utilization rate for the call line from the current FFS Medicaid and FAMIS populations.

The Nurse Line is to be utilized to provide health related support as described under this RFP to participants and to assist participants with referrals as needed.

Communication and Language Needs: The Contractor shall ensure that the communication and language needs of the enrollees are addressed. This applies to all non-English speaking participants and is not limited to prevalent languages. The enrollee cannot be charged a fee for translator or interpreter services. The Virginia Relay service for the deaf and hard-of-hearing must be used when appropriate.

The Nurse Line shall provide professional, prompt, and courteous customer service. Telephone staff shall greet the caller and identify themselves by name when answering. The Contractor shall establish and maintain an adequately staffed Nurse Line Center and shall ensure that the staff treats all callers with dignity and respect the caller's right to privacy and confidentiality. The Contractor shall process all incoming telephone inquiries for DM services in a timely, responsive, and courteous manner.

The Contractor agrees to relinquish ownership of the toll-free and/or local number(s) upon contract termination, at which time the Department shall take title to the telephone number(s). Any amount owed on these numbers shall be the sole obligation of the Contractor.

The Nurse Line shall:

- Be toll-free for participants and providers.
- Be staffed by medical professionals who are fully trained, have the appropriate licensure for their profession, and are knowledgeable about Virginia Medicaid and FAMIS standards and protocols.
- Have the capacity to handle all telephone calls at all times during the hours of operation; and have the upgrade ability to handle any additional call volume. Any additional staff or equipment needs shall be

the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment for all hours, including high peak times.

- Have sufficient telecommunications capacity to meet the performance standards specified in this section. This capacity must be scalable (both increases and decreases) to demand in the future.
- Effectively manage all calls received and assign incoming calls to available staff in an efficient manner. Include a capability to track and report information on each call. It must have the capability to produce an electronic record to document a synopsis of all calls and to provide a complete record of communication to the call line from providers, participants, and other interested parties. The tracking must include sufficient information to meet the reporting requirements in Section 4.14.
- Have Contractor staff who are responsive, helpful, courteous and accurate when responding to inquiries, and who maintain enrollee confidentiality. The Contractor shall be responsible for a Quality Assurance program that shall be in place to sample calls and follow up calls to confirm the quality of responses, and caller satisfaction. The Contractor shall be responsible for reporting on the outcomes of the Quality Assurance program, and for providing any training required to maintain the highest level of quality.
- Be compliant with Medicaid and FAMIS confidentiality procedures/policies, including HIPAA requirements, within the nurse call line department.
- Provide a greeting message when necessary and educational messages approved by the Department while callers are on hold.
- Install and maintain its telephone line in a way that allows calls to be monitored by a third party for the purpose of evaluating Contractor performance with a message that informs callers that such monitoring is occurring. Call monitoring by a third party, for accuracy and quality of information, must be available at the location of the Nurse Line center.
- Ensure that telephone interpreter services are accessible via the toll-free number and that providers/participants will not have to hang up to access these services.
- Provide TDD/TDY access.

4.3.1 Nurse Line Center Performance Standards

The Contractor shall be responsible for meeting the following performance standards and is required to provide reports (detailed in Section 4.14) demonstrating that it has met or exceeded the standards:

- The Nurse Line shall be available to respond to inquiries except for down time for which the Contractor has received prior written approval from the Department, excluding Acts of God.
- The Contractor shall provide sufficient staff, facilities, and technology such that 95 percent of all call line inquiry attempts are answered. The total number of busy signals and abandoned calls measured against the total calls attempted shall not exceed ten percent in any calendar week.
- Calls must be answered within three rings or 15 seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The wait time in the queue should not be longer than three minutes for 95 percent of the incoming calls.
- All call line inquiries that require a call back, including general inquiries, shall be returned within one business day of receipt 99 percent of the time.

In response to this RFP, the Offeror shall submit call center performance data for contracts of a similar scale as outlined in this RFP.

4.3.2 Nurse Line Reporting

Call center reporting shall be provided weekly for the first eight weeks after program implementation and monthly thereafter, and, at a minimum, shall include the following:

a. Total hours of daily call center access provided, hours of downtime, and an explanation of why downtime occurred.
b. Overall call volume, by type of call, including nature of inquiry and source of call. (Must provide a separate report for provider and enrollee calls.)
c. Call abandonment rate, and average time prior to abandonment, including calls placed on hold.
d. Wait time for customer service representative and/or clinician on hold.
e. Comprehensive report on the nature of calls received, with counts of the twenty most frequent types of calls handled during the week or month.
f. Detailed statistics regarding participant or provider grievances.
g. Average time required to call back when a call back was required and the percent of all call backs that took more than 24 hours.
h. Average length of calls handled.
i. Outcomes of quality improvement measurements.

The Nurse Line must have the capacity to track individual provider and participant call activity and capture important aspects covered during the call transaction. The Contractor must report individual call activity data to the Department upon request.

4.4 Staffing Requirements

4.4.1 Office Location

It is preferred the Contractor maintain a physical business office in Virginia. If not located in Virginia, the business office must be located within the United States. The Offeror may specify who will be located in the business office, but at a minimum, the Project Director shall be located in the office.

4.4.2 Staffing Plan

4.4.2.a The Contractor shall not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State.

4.4.2.b The staffing for the plan covered by this RFP must be capable of fulfilling the requirements of this RFP. A single individual may not hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A Project Director specifically identified with overall responsibility for the administration of this RFP. The Project Director shall serve as the liaison to the Department by communicating with the Department's contract monitor regarding service issues. This

person shall be at the Contractor's officer level and the percentage of time the person is dedicated to the RFP must be approved by the Department, including upon replacement. Said designee shall be responsible for the coordination and operation of all aspects of the RFP.

2. Sufficient trained and experienced support staff to conduct daily business in an orderly and efficient manner, including such functions as administration, accounting, appeal resolution system, as determined through management and medical reviews.

3. Sufficient trained and experienced administrative and clinical staff who can address the unique needs of the enrollees while assuring that services are provided in the most economical manner.

4. A physician who is licensed by and physically located in the Commonwealth of Virginia to serve as Medical Director to chair and oversee the Contractor's Quality Assurance Committee to ensure the proper provision of DM Program services to enrollees.

5. A quality assurance coordinator to coordinate requirements described in Section 3 of this RFP.

6. Sufficient staff who are trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to the Department.

7. A staff of qualified, medically trained personnel, whose primary duties are to maintain a toll-free Nurse Line to be responsible for assisting enrollees in answering their health related questions; assisting enrollees to make appointments and to obtain services; and to handle enrollee inquiries and grievances.

8. The Contractor's staffing plan must include the materials and methods used (on-going) for training staff, including the handling of the nurse call line and other telephone inquiries. The Contractor shall provide copies of all training materials and a description of methods used for training staff with this RFP submission and annually thereafter.

9. The Contractor shall identify in writing the name and contact information for the Project Director and the Medical Director at the implementation of the program. Key contact persons shall also be provided for Accounting and Finance, Nurse Line, Case Management, Information Systems, and Enrollee Services within thirty (30) days of DM program implementation. The Department reserves the right to require the Contractor to select another applicant for any of these positions. The Contractor must notify the Department of any changes in staff persons during the term of this RFP in writing within 10 business days.

10. If any member of the project management team, as identified in the Contract, becomes unavailable for any reason, the Contractor shall advise the Department immediately, and shall provide an expected timeline for the re-hire. The Department reserves the right to approve or reject rehires to project management level positions.

11. Failure to maintain the required staffing level to meet contract requirements may result in a reduction in the Department's administrative payments to the Contractor. Reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Contractor. The Contractor shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

4.4.2.1 The Contractor's failure to comply with staffing requirements as described in this RFP shall result in the application of intermediate sanctions and liquidated damages as specified in Attachment VI of this RFP.

4.4.3. Licensure

The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and the Department may terminate this RFP for cause as described in Section 10.7.1 of this RFP.

4.5 Outreach Activities

4.5.1 Contractor's Outreach to Encourage DM Program Participation

The Contractor shall conduct outreach activities designed to inform DM-eligibles about the availability of the DM program and to increase enrollee participation in the DM program. The Department will work with the Contractor to develop a letter that is signed by the Department's Director that the Contractor shall send to DM-eligibles to inform them the DM program is a part of their Medicaid or FAMIS benefits. Any related materials for outreach activities are subject to approval by the Department. The Department shall have fifteen (15) calendar days to review material and provide notice of approval or notice to make changes. The cost of design, printing, and distribution (including postage) shall be borne by the Contractor. The Department may require the Contractor to coordinate its efforts with outreach projects being conducted by the Department or other state agencies.

The Contractor shall comply with all Federal postal regulations and requirements for mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and at no expense to the Department.

All outreach materials must meet requirements specified in Section 4.2.3. Failure to comply with the requirements of this Section may result in the application of intermediate sanctions or liquidated damages as provided in Attachment VI of this RFP.

4.6 Subcontractors

4.6.1 Legal Responsibility

The Contractor shall be responsible for the administration and management of all aspects of this RFP and the DM program covered there under. If the Contractor elects to utilize a subcontractor, the Contractor shall ensure that the subcontractor shall not enter into any subsequent agreement or subcontracts for any of the work contemplated under the subcontract for purposes of this RFP, without prior approval of the Contractor. No subcontract or other delegation of responsibility shall terminate or reduce the legal responsibility of the Contractor to the Department to ensure that all activities under this RFP are carried out.

4.6.2 Prior Approval

All subcontracts, amendments, and revisions thereto shall be approved in advance by the Department. All subcontracts shall be maintained in accordance with the applicable terms of this RFP. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the Department within 30 days of execution.

4.6.3 Notice of Subcontractor Termination

When a subcontract that relates to the provision of DM program services to participants is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how continuity of care will be maintained for the participants. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted participants of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment VI of this RFP. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

4.6.4 Notice of Approval

Approval of subcontracts shall not be considered granted unless the Department issues its approval in writing (to include e-mail). The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this RFP.

4.6.5 HIPAA Requirements

To the extent that the Contractor uses one or more subcontractors or agents to provide services under this Contract, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign a Business Associate Agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor pursuant to this Contract. The Department shall have the option to review and approve all such written agreements between the Contractor and its agents and subcontractors prior to their effectiveness.

4.7 Enrollee Grievance to the Contractor

The Contractor shall have a grievance process in place available to Medicaid and FAMIS enrollees who wish to file a grievance. This process must assure that appropriate decisions are made as promptly as possible. The Contractor must develop policies and procedures regarding the grievance processes. These must be reviewed and approved by the Department prior to implementation. The Contractor will provide DMAS with monthly reports indicating the number of grievance requests received as well as the detailed analysis and disposition.

4.8 Clinical Outcomes, Quality and Utilization Management

4.8.1 Quality and Appropriateness of Care

Contractor shall prepare for the Department's approval a written description of a quality monitoring/quality improvement (QM/QI) program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of DM services.

Evaluation methods shall include the following (unless otherwise specified, all measures are collected by the Contractor, reported to and analyzed by the Department):

4.8.1.1 For participant diseases and conditions, the Contractor will be asked to identify clinical outcomes using, at a minimum, the clinical variables identified in Attachment VII and identify any additional clinical variables that will be used to measure improvement in adherence to evidence-based guidelines for care. These clinical variables and outcomes will be measured for participants at baseline and every six months or in accordance with the timeline recommended by the Department.

4.8.1.2 The Contractor will use a standardized tool to measure health and functional status at baseline and every six months thereafter. Other measures of participant health status and function, and knowledge of disease management processes will be reported to the Department as collected.

4.8.1.3 For participants, the Contractor will measure utilization of medical services. Measures should include, at a minimum, the number of hospital admissions and readmissions, the number of emergency room visits, ambulatory visits and HEDIS® measures as specified in Attachment VIII. Utilization must be measured at baseline and monitored on a semi-annual basis for trends.

4.8.1.4 Participant satisfaction with the DM program and staff will be measured by a third party vendor semi-annually, or in accordance with the timeline recommended and analyzed by the Department.

4.8.1.5 The Contractor will use a third party vendor to document participant experience, and measure access to, and satisfaction with health care annually or in accordance with the timeline recommended by the Department.

4.8.1.6 The Contractor will measure net savings by developing a predictive model of expected expenditures (the methodology must be approved by the Department) and comparing the expected expenditures to actual expenditures less program costs. Health care expenditures include inpatient hospital, outpatient hospital, physician, pharmacy, lab and x-ray expenditures. All DM-eligibles identified by the Contractor shall be included in the analysis. It is expected, based on the contractor's methodology, that the number of DM-eligibles identified by the Contractor will be less than the number of potential eligibles identified in Attachment IV of this RFP.

The plan(s) shall describe who is responsible and the role of the Contractor's Medical Director in the Quality Management/Quality Improvement (QM/QI) program. In response to this RFP, the Contractor shall submit QM/QI materials from contracts that are similar in scale to the requirements outlined in this RFP.

4.8.3 QM/QI Meeting Requirements

The Contractor shall provide the Department Disease Management (DM) Contract Monitor with ten calendar days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee. These meetings may take place in the form of a conference call. To the extent allowed by law, the DM Contract Monitor of the Department, or his/her designee, may attend or listen in on the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be provided to the Department.

4.8.4 Policies and Procedures

The Contractor shall provide annually, or more frequently as revisions occur, a written copy of its DM Program policies and procedures to the Department for approval. The Department shall have thirty (30) calendar days to review and approve or request modifications to the policies and procedures. Should the Department not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the Department from requiring the Contractor to respond or modify the policy or operating guideline prospectively.

4.8.5 Exceptional Quality Improvement and Utilization Management Processes

The Offeror must submit the following as part of its proposal:

i. The Offeror's proposed quality improvement plan (QIP), to include linkages with administrative areas, and a description of the QI committee and its composition.

ii. A description of how the Offeror's enrollee grievance process is linked to the QI program.

4.8.6 Performance Reviews

The Contractor shall cooperate with any performance review conducted by the Department, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the RFP. Upon reasonable notice, the Department may conduct a performance review and audit of

Contractor to determine compliance with the RFP. At any time, if the Department identifies a deficiency in performance, the Contractor will be required to develop a corrective action plan to correct the deficiency including an explanation of how enrollees will continue to be served until the deficiency is corrected.

4.8.7 RFP Transition Plan

The Contractor that will cover coronary artery disease and congestive heart failure in its DM program must submit, as part of the proposal response, a transition or continuation of coverage plan that documents how it will provide coverage to the participants that are receiving DM program services the day before the effective date of this RFP.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the Department as directed to identify participants who were receiving DM services through the *Healthy Returns*SM pilot prior to the effective implementation date of this RFP. The Contractor will accept and honor those receiving services prior to the implementation of the Contract who remain DM participants.

The proposed DM program will initially be voluntary ("opt-in") for program participants; however, the Department will be pursuing federal approval to change the DM program into a mandatory, or "opt-out" model. Any technical contract modifications will be made at the time federal approval is received to operate a mandatory DM program. The Contractor needs to discuss in the proposal how they plan to address transitioning from a voluntary to a mandatory program.

4.8.8 Transition Management

The Contractor that receives a contract to cover coronary artery disease and congestive heart failure as a part of its DM program shall coordinate with the Department's current DM Contractor to effect a smooth transition of DM program services. Transition management includes coordination of care and a process whereby DM program inquiries received on or after the RFP implementation are redirected to the Contractor.

The Contractor must also address how it plans to transition DM participants who are moving into managed care as part of MCO expansion.

4.9 Provider Education

The Contractor shall provide educational materials to primary care providers or physicians of DM-eligibles or DM program participants. The Contractor is responsible for submitting all educational materials to the Department for approval at least thirty (30) calendar days prior to the use of the materials. The Department shall have fifteen (15) calendar days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) calendar days of receipt of the Department's comments.

The Contractor must provide documentation of all educational activities to the Department on an annual basis.

4.10 Referral Assistance

The Contractor shall make reasonable efforts to assist participants with contacting Medicaid providers to obtain referrals as needed. The Contractor shall follow up with the participant (and when necessary the provider) to make sure that the enrollee receives a referral from a health care provider. The Contractor shall track and report to the Department monthly the number of instances the Contractor provided assistance with obtaining a referral.

4.11 Contractor Database

In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, the Contractor shall maintain a HIPAA compliant database, in a format acceptable to the Department, capable of recording and maintaining participant protected health information (PHI) for the DM program; and retrieving data on short notice.

4.11.1 Data Base Requirements

In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, Contractor shall maintain a current database, in a format acceptable to the Department, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

Enrollee Name;
Medicaid or FAMIS ID #;
Enrollee Social Security Number (SSN);
Enrollee's Disease/Condition(s);
Date Enrollee was sent outreach materials;
Date Enrollee refused DM Program or accepted DM Program and why;
Health Assessment Information, to include:
    Date Assessment Conducted;
    Goals established;
Medicaid Provider Name;
Medicaid Provider Number;
All dates of contact with Physician/Provider and nature of contact;
All dates and types of referrals made, if requested;
All care management contact made, and outcome of contact;
Any other data element required by common practice, DMAA guidelines, federal or state law.

Data stored in the database shall be current through the prior week. The Virginia specific DM program data stored in the Contractor's database shall be the property of the Department.

4.11.2 Systems Readiness Review

The Contractor will work with the Department to ensure that the Contractor's database satisfies the functional and informational requirements of Virginia's DM program. The Contractor will assist the Department in the analysis and testing of the information systems as necessary prior to the delivery of services.

4.11.3 System Security

The Contractor will apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in an Information Security Plan provided prior to the delivery of services. The risk analysis will also be made available to appropriate Federal agencies.

The following specific security measures should be included in the system design documentation and operating procedures:

i. Computer hardware controls that ensure acceptance of data from authorized networks only.

ii. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes.

iii. Manual procedures that provide secure access to the system with minimal risk.

iv. Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel.

v. All Contractor database software changes related to the DM program may be subject to the Department's approval prior to implementation.

vi. System operation functions must be segregated from systems development duties.

4.11.4 Disaster Preparedness and Recovery at the Site

The Contractor must submit evidence that it has a Business Continuity/Disaster Recovery plan for its Central Processing Site. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the contract and must meet the requirements of any applicable state and federal regulations, and of the Department.

The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements:

i. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue receiving calls, processing prior authorizations, claims, and other functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's disaster plan must include provisions in relation to the call center telephone number(s).

ii. Employees at the site must be familiar with the emergency procedures.

iii. Smoking must be prohibited at the site.

iv. Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel.

v. Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.

vi. The site must be protected by an automatic fire suppression system.

vii. The site must be backed up by an uninterruptible power source system.

4.12 Connectivity to Medicaid Management Information System (MMIS)

The Contractor may not transmit PHI over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 164.308(e). If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

All expenses incurred in establishing connectivity between the Contractor the MMIS fiscal agent, First Health Services Corporation (FHSC) will be the responsibility of the Contractor. Connectivity to MMIS must be operational thirty-days prior to implementation.

4.12.1 Contractor Electronic Access to Department Eligibility and Claims Data

The contractor will "pull" the monthly claims data from the MMIS fiscal agent, First Health Services Corporation (FHSC) in a HIPAA compliant fashion either by dedicated data line FTP or secure FTP. The fiscal agent will require the execution of a trading partner agreement for EDI connection. The contractor shall describe in detail which of the following four (4) options they will pursue for connectivity.

4.12.1.a Private Connection

The DMAS MMIS fiscal agent's Phoenix Data Center (PDC) supports DS3 Frame Relay connections to two carriers (MCI Option 1 & AT&T). FHSC provides and maintains the shared access routers and local loops into the PDC. The Contractor maintains all connectivity/equipment at their location. The Contractor pays for the PVC between sites. If connectivity redundancy is required, the Contractor is allowed to establish connections to both carriers.

The Contractor can also deliver any router(s)/carrier(s) connectivity into the PDC at their own expense. Allowing for available bandwidth, FHSC can allow the Contractor's local loop to ride the PDC Private Sonet Ring. The Contractor is responsible for the maintenance of all supplied equipment. PDC staff will validate power and physical connectivity for the equipment.

4.12.1.b Site to Site VPN

The Cisco 3060 VPN Concentrator located at PDC offers support for up to 5000 simultaneous IP Security (IPSec) sessions. The 3060 is a VPN platform designed for large organizations that require the highest level of performance and reliability and that have high-bandwidth requirements from fractional T3 through full T3/E3 or greater (100 Mbps maximum performance).

The Contractor can also deliver a VPN device to be hosted in an isolated "Extranet VLAN". VPN traffic will be tunneled through the Internet Firewall's to the VPN device for decryption/delivery to the DMZ Firewall. The Contractor is responsible for the maintenance of all supplied equipment. PDC staff will validate power and physical connectivity for the equipment. A Site to Site IPSEC VPN can be established between the Contractor and the FHSC Cisco 3060 VPN concentrator. The VPN will secure all traffic passing between the sites. The Concentrator and Firewalls will restrict the physical access to only allowed hosts.

4.12.1.c Secure FTP

The Contractor would also be able to access the FHSC Secure File Transfer Server over the Internet. This product supports the FTPS (SSL FTP/AUTH SSL) protocol to secure all communications between the Contractor and the server. An area on the server will be created for the Contractor to PUT and GET files. Files that the Contractor needs to upload to the Secure FTP server will be automatically be routed to their respective hosts without the partner's interaction.

As a prerequisite prior to establishing the Secure FTP communications, a trading partner agreement must be completed with FHSC.

FHSC supports Secure Sockets FTP over the Internet that complies with RFC 959, 1123, and 2228. The Contractor is required to use a 128-bit SSL client software package, at the Contractor's expense that supports passive mode. FHSC also supports PGP.

4.12.1.d Connect Direct

The contractor can support connection using a node on the Connect Direct network.

4.12.2 DMAS Access to Contractor Database

There will be no direct connection to DMAS from the contractor. The contractor will provide access to DMAS via 128-bit SSL web front end to the application (e.g., Secure CITRIX server). All application operations must be able to be done via a web browser from DMAS workstations. Therefore, the application must be web enabled.

The Contractor will be expected to provide DMAS with a written Communications Plan to include communications security that describes the use of data that will be transmitted to DMAS or FHSC or reside

in the custody of the Contractor. FHSC may also require an executed HIPAA trading partner agreement with the Contractor.

4.12.3 DMAS Remote Access/Email Communications:

The Contractor will provide SSL secure email access over the Internet between DMAS and the Contractor. No direct connection or VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. Such secured email will only require DMAS staff to use a 128-bit SSL enabled web browser to access from the contractor or send email to the contractor. DMAS will provide no special application server(s) for this purpose on its side nor accept contractor provided server(s).

4.12.4 Enforceability and Admissibility

Any document properly transmitted pursuant to this Contract will be deemed for all purposes (1) to be a "writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

4.12.5 Timeliness, Accuracy, and Completeness of Data

The Contractor must ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, Nurse Line and outcome reports will be submitted via electronic media or via the web in accordance with Department criteria.

In the event that electronic data files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within thirty (30) calendar days. The Contractor agrees to correct encounter claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this RFP.

4.13 Transition Upon Termination Requirements

At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor after termination or expiration of the Contract, the Department shall notify the Contractor of the need for transition. Such notice shall be provided at least sixty (60) calendar days prior to the date the Contract will expire, or at the time the Department provides notice of termination to Contractor, as the case may be. The transition process will commence immediately upon such notification and shall, at no additional cost to the Department, continue past the date of contract termination or expiration if, due to the actions or inactions of Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor will negotiate in good faith a contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer,

the Contractor will continue to perform operations on a month-to-month basis for up to six months beyond the planned transfer date. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete.

4.13.1 Close Out and Transition Procedures:

4.13.1.a Within ten (10) business days after receipt of written notifications by the Department of the initiation of the transition, Contractor shall provide to the Department a detailed electronic document, containing the following:

i. The number of individuals enrolled in the DM program;
ii. Each participant's name and identification number; and
iii. Information on any pending grievances.

4.13.1.b Within ten (10) business days after receipt of the detailed document, the Department will provide Contractor with written instructions, which shall include, but not be limited to, the following:

i. The packaging, documentation, delivery location, and delivery date of all records, data and review information to be transferred. The delivery period shall not exceed thirty (30) calendar days from the date the instructions are issued by the Department.

ii. The date, time and location of any transition meeting to be held among the Department, Contractor and any incoming Contractor. Contractor shall provide a minimum of two (2) individuals to attend the transition meeting and those individuals shall be proficient in and knowledgeable about the materials to be transferred.

4.13.1.c Within five (5) business days after receipt of the materials from Contractor, the Department shall submit to Contractor in writing any questions the Department has with regard to the materials transferred by Contractor. Within five (5) business days after receipt of the questions, Contractor shall provide written answers to the Department.

4.13.1.d All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Department. On request, the Contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Department to evidence the Department's sole ownership of specifically identified intellectual property created or developed in the performance of the contract. This includes but is not limited to the Nurse Line telephone number established for the Department's DM program.

4.14 Reporting Requirements

The Contractor must maintain data necessary to complete reports specified in Sections 4.14.2 through 4.14.13.

4.14.1 Care Management Report

The Contractor shall submit a monthly report that shall include a summary of the care management provided as part of the Tasks described in Section 3. The first report under this RFP, covering the month of November 2005, shall be due on December 15, 2005. Thereafter, reports shall be due fifteen (15) days after the end of each calendar month. The report shall provide sufficient information to allow the Department to determine:

a. The number of participants receiving care management;
b. The number of initial screenings completed;
c. The number of times participants were contacted, how often they were contacted, and the outcome of the contact;
d. Any contacts made on behalf of the participant to providers, physicians, and the reason why;
e. Any referrals made, the reason why, and the outcome of the referral;
f. Measured progress toward stated goals or each participant (describe successful outcomes as well as barriers)
g. If a risk stratification process is used, the report shall also contain the number of participants in each level of care.

4.14.2 Audited Financial Statements and Income Statements

The Contractor shall provide to the Department copies of its annual audited financial (or fiscal) statements no later than ninety (90) calendar days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) calendar days after the end of each calendar quarter.

4.14.3 Outreach and Participation Reports

The Contractor shall provide a quarterly Outreach and Participation Report that describes the DM related outreach activities completed in the preceding three months, and the results of those activities. At a minimum, the results shall include:

a. The method of contact and the number of DM-eligibles identified, their geographic location;
b. The number of DM-eligibles the Contractor was unable to contact, and why;
c. The number of contacts attempted;
d. The number of DM-eligibles reached. Of those reached, the number of DM-eligibles who chose to participate and were enrolled (for the voluntary program);
e. The number of participants enrolled in the pgoram;
f. The number of DM-eligibles who opted out of the program and why;
g. The number of participants who were enrolled in the program and their demographic information (race, age, and gender);
h. The length of time participants have been enrolled (by disease state and risk level); and
i. The number of participants who disenroll from the program, and an explanation of reason for disenrollment.

The report shall also contain lessons learned from outreach activities and how future activities will be modified to incorporate lessons learned.

4.14.4 Nurse Line and Additional Call Line Activity Reports

Nurse Line or Call center reporting shall be provided bi-weekly for the first month after program implementation and monthly thereafter, and, at a minimum, shall include the following:

a. Total hours of daily call center access provided, hours of downtime, and an explanation of why downtime occurred.
b. Overall call volume, by type of call, including nature of inquiry and source of call. (Must provide a separate report for provider, enrollee and participant calls.)
c. Call abandonment rate, and average time prior to abandonment, including for calls placed on hold.
d. Wait time for customer service representative and/or clinician on hold; number and percentage of calls on hold that were answered by call line staff within twenty (20) seconds, and intervals thereafter.
e. Comprehensive report on the nature of calls received, with counts of the twenty most frequent types of calls handled during the week or month.
f. Detailed statistics regarding participant or provider grievances.
g. Average time required to call back when a call back was required and the percent of all call backs that took more than 24 hours
h. Average length of calls handled.
i. Outcomes of quality improvement measurements.

The Contractor must report individual call activity data to the Department upon request.

Monthly reports will be due fifteen (15) calendar days after the end of the calendar month being reported. At a minimum the report shall identify the total call volume, call type (e.g., grievance, appointment assistance, benefit inquiry, etc), wait time (in seconds), and the abandonment percentage rate, as described

4.14.5 Meeting Reports

The Contractor shall submit the minutes of its QM/QI meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported.

4.14.6 Satisfaction Surveys

The Contractor shall contract with a third party to conduct, at a minimum, a semi-annual Participant Satisfaction Survey and an annual Provider Satisfaction Survey. The survey questions and methodology shall be approved by the Department prior to conducting the survey. The Contractor shall submit a report identifying key findings to the Department within 30 days of the initiation of the survey. The Offeror shall submit a schedule with the proposal that outlines the timeframe the satisfaction surveys will be administered.

4.14.7 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this RFP.

4.14.8 Grievance Reports

The Contractor shall provide the number of grievances by type and the type of assistance provided as described in Sections 4.7 of this RFP.

4.14.9 Semi-Annual and Annual Report

The Contractor shall provide a semi annual and an annual report that provides a report card summary for all of the following activities: Enrollee and Provider Outreach, Nurse Line, Grievances and Appeals, Enrollee Participation, Care Management, and Health Care Expenditure Savings. The Offeror shall submit sample "annual report card" reports with their RFP Proposal. The Department shall approve the final reporting format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

4.14.10 Projected Participation and Utilization Goals Report

The Offeror shall include with its proposal projections, at a minimum, a projected percent of DM-eligibles the Offeror expects to enroll in the program each year.

In addition the Offeror shall report in detail the implementation strategy it will utilize to achieve the projected participation utilization. The Offeror's proposed strategy shall sufficiently describe the basis for the Offeror's administrative services organization (ASO) per member per month (PMPM) cost proposal.

4.14.11 Clinical Outcomes Report

The Contractor shall submit a semi-annual report that shall include a summary of the clinical outcomes provided as described in Section 4.8 and using variables described in Attachment VII of the RFP. At a minimum, the outcomes, when compared to the health status baseline, reflect:

a. The improved overall health status of participants;
b. The decrease in inpatient hospital admissions;
c. The decrease in total inpatient hospital days;
d. The decrease in non-emergent emergency room visits;
e. The increased coordination and reduction of unnecessary or inappropriate medications; and
f. The increase in participant self-management skills.

4.14.12 Utilization and Health Care Monthly Expenditures Report

The Contractor shall submit after the first year of operation and semi-annually thereafter a report that shall include a summary of the net savings as defined through the approved predictive modeling methodology.

The report shall also include a breakdown of changes to cost and utilization for at least the following services by disease state:

a. Inpatient hospital admissions and readmissions for enrolled participants;
b. Emergency room visits, ambulatory care visits, and inpatient days per admission for enrolled participants;
c. Prescription drugs; and
d. Utilization/physician office visits.

4.14.13 Other Reporting Requirements

The Contractor shall also provide up to three additional monthly and ad hoc reports in relation to the RFP (and resulting contract) requirements in a format as agreed upon by the Department and the Contractor. The Department shall incur no expense in the generation of such reports. Additionally, the Contractor shall make revisions in the data elements or format of the reports required in this RFP and resulting contract upon request of the Department and without additional charge to the Department. The Department shall provide written notice of such requested revisions of format changes in a notice of required report revisions. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this RFP. The Department may impose liquidated damages or monetary sanctions under Attachment VI of the RFP based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

4.15 Fraud and Abuse

4.15.1 Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR Parts 455 and 456. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

4.15.2 Fraud and Abuse Compliance Plan

a. The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department with this RFP and as an annual submission as part of the Contract. The Plan must define how the Contractor will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The Department shall provide notice of approval, denial, or modification to the Contractor within thirty (30) calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within thirty (30) calendar days of a request. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

a. Utilization management;
b. Relevant subcontractor and provider agreement provisions;
c. Written enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting by enrollees, network providers and subcontractors of plan violations to the designated person as described in item b. below;

iv. Contain provisions for the investigation and follow-up of any compliance plan reports;

v. Ensure that the identities of individuals reporting violations of the plan are protected;

vi. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

vii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to the Department and that enrollee fraud and abuse be reported to the Department;

viii. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

c. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within two (2) business days of initiation of any investigative action by the Contractor or within two (2) business days of Contractor notification that another entity is

conducting such an investigation of the Contractor, its network providers, or its enrollees. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices.

4.16 Readiness for Implementation

No later than October 17, 2005 the Contractor shall demonstrate, to the Department's satisfaction, that Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

- That the Contractor has thoroughly trained its staff on the specifics of the Virginia DM Program policies, and that Contractor's staff has sufficient medical knowledge to make determinations of DM needs;

- That the Contractor has trained its staff to handle telephone requests from enrollees, participating providers, and has provided to the Department copies of the materials and methods used for training and outreach;

- That the Contractor has successfully completed the requirements listed in Sections 4.11 and 4.12;

- That the Contractor has demonstrated the ability to submit and accept to the Department's satisfaction all required documentation with respect to the payments from the Department to the Contractor as described in Section 6; and

- That the Contractor's QM/QI, participant services, and other pertinent components are in place in accordance with requirements described in this RFP.

- The Contractor will have identified from DM-eligible individuals those with conditions that make them eligible for enrollment in the program.

The Contractor's inability to demonstrate, to the Department's satisfaction and as provided in this Section, that Contractor is fully capable of performing all duties under this contract no later than October 1, 2005, shall be grounds for the immediate termination of the Contract by the Department pursuant to the Department Special Terms and Conditions, 10.7 Cancellation of Contract rights.

4.17 Implementation

Administration of the DM Program by Contractor shall begin on November 1, 2005 ("Implementation"). Payment to Contractor as provided in Section 6 (Payments to the Contractor) of this Contract shall begin upon implementation. The Contractor shall not be compensated for any expenses incurred prior to the implementation begin date.

The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Department all such

information and data for this purpose as may be requested. The Department reserves the right to inspect Offeror's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Department that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

4.18 Internet Site

Contractor agrees to maintain an Internet site with a section or page devoted to enrollees and providers covered under the Virginia Medicaid and FAMIS programs. At a minimum, the site shall contain the following.

- An outline of coverage
- Other information about the plan, including how to enroll in the DM program
- Contractor contact names, telephone numbers, and addresses for individuals to contact with respect to services covered in this RFP
- How to obtain program information in non-English languages
- Information regarding how to submit grievances and or appeals to the Contractor
- Information to assist providers in relation to frequently asked questions, etc.

5. DMAS RESPONSIBILITIES

DMAS will oversee the DM program, including overall program management, determination of policy and monitoring of service. DMAS will work in partnership with the Contractor in developing a quality program. The primary responsibilities of DMAS include:

a) Make the final decision regarding all policy issues;
b) Provide on-going project oversight, management and evaluation to include announced and unannounced visits to ensure regulatory compliance;
c) Provide Contractor with relevant Medicaid and FAMIS eligibility and health care expenditure claims data for Medicaid and FAMIS enrollees and the physician provider file;
d) Conduct field observations of operations and the Nurse Line;
e) Monitor staffing levels, outreach to enrollees, enrollee utilization and other monitoring;
f) Review and approve any Contractor written policy, subcontracts and/or procedural communications to recipients, providers and others prior to release;
g) Provide training to local area agencies on aging, social service agencies, and other human service agencies/organization to inform and educate them about the DM program(s);
h) Attend/observe QI/QA activities;
i) Promoting the program by informing enrollees and contracted Medicaid providers;
j) Conduct an evaluation to include the barriers and successes of the DM program based on participant claims data and measures provided by the Contractor as specified in Section 4 of this RFP; and
k) Perform periodic audits of Contractor's contractual compliance. Such audits will commence upon 30 days written notice by the DMAS Division of Internal Audit to the Contractor that DMAS will be conducting a review of enumerated aspects of Contractor's contractual compliance. The scope and estimated duration of each such review will be specified in writing.

6. PAYMENTS TO THE CONTRACTOR

Payment processes described in this Section must be tested as part of the readiness for implementation review described in Section 4. Any changes required to the Contractor's processes as identified through readiness review activities shall be made by the Contractor prior to implementation. Costs associated with these changes shall be borne by the Contractor.

6.1 Annual Review of Controls

The Contractor shall provide to the Department and the State Treasurer a statement from its external auditor that a review of the Company's internal accounting controls reveal no conditions believed to be a material weakness in the proper administration of the Department's DM Program in accordance with sound business principles. The written statement shall be provided annually each June 15 for the preceding calendar year.

6.2 Payment Methodology.

6.2.1 Administrative Services Organization (ASO) Payments

The Contractor shall be compensated for ASO responsibilities based on a fixed fee per member per month (PMPM) as determined by the RFP award and subsequent contract negotiations. Each monthly payment to the Contractor shall be equal to the number of enrollees certified by the Department multiplied by the administrative fee for the appropriate enrollee-funding category. The enrollee funding category for a statewide contract shall include Medicaid and FAMIS fee-for-service enrollees who have asthma, diabetes, congestive heart failure, and/or coronary heart failure. A separate enrollee funding category will be determined for individuals with asthma and/or pediatric diabetes if contracts are awarded specifically for these conditions. Eligible Medicaid and FAMIS categories make up the PMPM rate category and shall be reimbursed at the PMPM rate of reimbursement. However, for Federal funding reporting, and tracking purposes the payments must be reported separately, as shown in the table below.

The Contractor's payment shall be based on enrollment reported by the Contractor of DM-eligibles identified by the Contractor who chose to participate in the DM "Opt-In" program (or minus those who chose not to participate, when the "Opt-Out" program is implemented). The Contractor shall report the number of participants enrolled to the Department in an enrollment report by the 25th day of each month of the contract period. Payment will be made to the Contractor on the subsequent month following confirmation of enrollment. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility. The Department shall arrange for payment each month at an agreed upon time by the Department and the Contractor for administrative payments as described herein.

"Opt-In" Program

	Pediatric Disease Management			Adult
Effective Date	Medicaid Children	Medicaid Expansion	FAMIS	Medicaid Adults
November 15, 2005 – November 14, 2006	$ PMPM	$ PMPM	$ PMPM	$ PMPM

November 15, 2006 – November 14, 2007	$ PMPM	$ PMPM	$ PMPM	$ PMPM
November 15, 2007 – November 14, 2008	$ PMPM	$ PMPM	$ PMPM	$ PMPM

*PMPM: Per Member Per Month

"Opt-Out" Program

	Pediatric Disease Management			Adult
Effective Date	Medicaid Children	Medicaid Expansion	FAMIS	Medicaid Adults
November 15, 2005 – November 14, 2006	$ PMPM	$ PMPM	$ PMPM	$ PMPM
November 15, 2006 – November 14, 2007	$ PMPM	$ PMPM	$ PMPM	$ PMPM
November 15, 2007 – November 14, 2008	$ PMPM	$ PMPM	$ PMPM	$ PMPM

*PMPM: Per Member Per Month

All costs for service provided in the proposal and resulting contract shall be included in the PMPM cost and the PMPM cost is the sole consideration to be received by Contractor for performance of the contract. There shall be no separate compensation for any other costs, including but not limited to, supplies or any other expense.

6.2.2 The Department anticipates but will not require a minimum net savings guarantee on per member per month participant health care expenditures for each State Fiscal Year. Cost proposals that offer a guaranteed net savings will receive a disproportionately higher score than those who do not offer a guaranteed net savings.

6.3 Travel Compensation

The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

6.4 Payment of Invoice

The payment of the invoice by the Department shall not prejudice the Department's right to object to or question any invoice or matter in relation thereto. Such payment by the Department shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

6.5 Invoice Reductions

The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Department, on the basis of audits conducted in accordance with the terms of this RFP, not to constitute proper remuneration for compensable services. This shall include any reductions based on projected reductions in overall health care expenditures and projected clinical outcomes of DM program participants (proportionate savings) that are not realized by the Contractor each State Fiscal Year.

6.6 Deductions

The Department reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the Commonwealth of Virginia any amounts which are or shall become due and payable to the Commonwealth of Virginia by the Contractor, including but not limited to liquidated damages assessed as described in Attachment VI to this RFP.

7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements for each proposal and the specific requirements for the Technical Proposal and the Cost Proposal.

General Requirements for Technical Proposals and Cost Proposals

7.1. Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

7.1.1 Critical Elements of the Technical Proposal

The Offeror must cross reference its Technical proposal with each requirement listed in Section 4 of this RFP. In addition, the Offeror must assure that the following documentation is included in the proposal.

Projected Participation and Utilization Goals: As described in Sections 3 and 4, the Offeror shall include with its proposal projections for the next three years for recipient participation. In addition the Offeror shall report in detail the implementation strategy it will utilize to achieve the projected utilization goals, and how satisfaction will be measured.

Care Management: As described in Section 3, using the Department's base-line benchmarks reflected in this RFP, the Offeror shall include with its proposal how care management services will be provided. The

Offeror shall report in detail the implementation strategy it will utilize in care management to achieve the projected clinical outcomes and a reduction in health care expenditures.

Clinical Outcomes: As described in Sections 3 and 4, using the Department's base-line benchmarks reflected in this RFP, the Offeror shall include with its proposal projections for the next three years for clinical outcomes. The Offeror shall report in detail the implementation strategy it will utilize to achieve the projected clinical outcomes and how clinical outcomes will be measured.

Implementation Plan: Submit a detailed implementation plan demonstrating the Offeror's proposed schedule to implement the DM program no later than October 17, 2005.

Implementation Schedule: The Contractor shall implement the DM program described in this RFP no later than December 31, 2005. The Contractor shall provide a detailed implementation and work plan, including deliverables and timelines, as part of the proposal. A comprehensive report on the status of each subtask, tasks, and deliverables in the work plan will be provided to the Department by the Contractor every week during implementation.

Plan for Outreach and Increased DM Program Utilization: Submit a detailed description of the manner in which Offeror proposes to perform the responsibilities detailed in Section 4.5. The plan must include a step-by-step description of the procedures by which each requirement will be met.

Education: Submit a description of the Offeror's plan to educate Virginia Medicaid DM-eligibles, providers, and others with an interest in the DM program. The Offeror should recommend education and notification processes and methods to the Department to increase compliance rates and minimize transition disruptions. The plan must include education activities prior to and after implementation.

Nurse Line: Submit a detailed description of how the Offeror will staff and operate a toll-free Nurse Line. The plan must describe the information and assistance that will be provided by Nurse Line representatives.

Staffing: The Contractor must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Contractor's plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide or Procedures Manual.

Auditing: Submit a description of how all activities will be audited and how Nurse Line (or other telephone lines, if applicable) responses will be monitored to ensure accuracy of information provided to callers. This section must also describe a plan to ensure confidentiality of records.

Transition of Care: Submit a detailed description of how the Offeror will minimize disruption to enrollees and providers particularly in relation to start-up transition of care issues as described in Section 4.13.

Predictive Modeling Methodology: Submit a detailed description of how the Offeror will calculate the expected per member per month health care expenditures for the program years. The methodology shall:

- Be based on sound, accepted statistical techniques of predictive modeling.

- Use Medicaid/FAMIS claims history data for the population of DM-eligibles identified for outreach and potential enrollment into the DSM program adjusted for days of eligibility.

- Determine payments for a fiscal year based on service date, with a claims run-out period of at least three months.

- Account for the nature of the health care field, such as nonlinear relationships between variables, outliers, utilization trends, co-morbidities, disease severity, and demographics.

The difference between the expected per member per month health care expenditures and the actual per member per month health care expenditures less program costs shall be considered the net savings. Include with the proposal the proposed net savings the Offeror expects to generate through the DSM program.

7.2 Binding of Proposal

The Technical Proposal shall be clearly labeled "Technical Proposal" on the front cover. The Cost Proposal shall be clearly labeled "Cost Proposal" on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit an original and ten (10) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP 2005-06 Technical Proposal". In addition, the original of the Cost Proposal shall be sealed separately and clearly marked "RFP 2005-06" and submitted by the response date and time specified in this RFP. The Cost Proposal form in Attachment IX shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2000 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2000 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy of their Technical Proposal and their Cost Proposal.

7.3 Table of Contents

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 4: "Technical Proposal Requirements." Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

7.4 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror's proposals. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror's collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of §2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, women-owned businesses and minority-owned business shall be submitted with the Technical Proposal.

7.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda.

At a minimum, the transmittal letter shall contain the following:

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
   a) The Offeror must identify any contracts or agreements they have with any state or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program provider or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
   b) Offeror must be able to present sufficient assurances to the state that the award of the contract to the Offeror will not create a conflict of interest between the Contractor, the Department, and its subcontractors; and
   c) The Offeror must be licensed to conduct business in the state of Virginia.

2. A statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;
4. Designation of an individual as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract; and
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to DMAS.

7.6 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda, if issued, to the RFP, and submit them along with its proposal.

7.7 Procurement Contact

The principal point of contact for this procurement in DMAS shall be:

Karen Lawson
Senior Policy Analyst, Policy and Research Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail: dsm@dmas.virginia.gov

All communications with DMAS regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact or the DMAS Contract Management Officer. An Offeror who communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from this procurement.

7.8 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 2:00 p.m. local time on June 27, 2005. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:

Attention: Christopher Banaszak
Department of Medical Assistance Services

600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
1st Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

If DMAS does not receive at least one responsive proposal as a result of this RFP, DMAS reserves the right to select a Contractor that best meets DMAS' needs. DMAS management shall select this Contractor. DMAS also reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the DMAS web site, http://www.dmas.virginia.gov/.

7.9 Oral Presentation and Site Visit

DMAS may require one or more oral presentations by an Offeror in response to questions DMAS has about the Offeror's proposal. An oral presentation means that the Offeror is physically present in a DMAS designated meeting room. DMAS will allow a minimum five-business day advance notice to the Offeror prior to the date of the oral presentation. Expenses incurred as part of the oral presentation shall be the Offeror's responsibility.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract, both Medicaid and non-Medicaid. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

7.10 Technical Proposal

The following describes the required format, content and sequence of presentations for the Technical Proposal:

7.10.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the Offeror's:

1. Understanding of the project requirements.
2. Qualifications to serve as the DMAS Contractor for the project.
3. Overall Approach to the project and a summary of the contents of the proposal.

7.10.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the Offeror's qualifications and experience to serve as the Contractor. Specifically, the Offeror shall describe its:

1. Organization Status:
    a) Name of Project Director for this Contract;
    b) Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
    c) Federal employer ID number;
    d) Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);
    e) Name of the parent organization;
    f) Major business services;
    g) Legal status and whether it is a for-profit or a not-for-profit company;
    h) A list of board members and their organizational affiliations; and
    i) Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience:
    a) Offeror's overall qualifications to carry out a project of this nature and scope.
    b) The Offeror shall describe the background and success of the Offeror's organization and experience in performing disease management services or other human services, specifically implementing state, local or regional programs.
    c) The Offeror's knowledge of the Medicaid and/or FAMIS recipient populations and the communities.
    d) For each experience with operating, managing, or contracting for the provision of disease management services or other human services, the Offeror shall indicate the contract or project title, dates of performance, scope and complexity of contract, and customer references (see below).
    e) Any other related experience the Offeror feels is relevant shall be included.
    f) The Offeror shall indicate whether the Offeror has had a contract terminated for any reason within the last five years.
    g) The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References:
    a) Two customers or participants who will substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP.
    b) Two customers or participants who can attest to the Offeror's experience with interface files for data loads.
    c) Contact information for all disease management contracts for Medicaid or FAMIS products and any Virginia based non-Medicaid groups the Offeror chooses to include, held by the Offeror at any time since January 1, 1999.

The Offeror shall complete the Reference Form in Attachment X for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:

The Offeror shall submit evidence of financial stability. The Offeror should submit one of the following financial reports:

a) For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization, or
b) For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

7.10.3 Chapter Three: Tasks and Technical Approach

The Offeror shall fully describe how it intends to meet all of the tasks required in Section 3 of the RFP and technical proposal requirements listed in Section 4 of this RFP. DMAS does not want a "re-write" of the RFP requirements. Specifically, the Offeror shall describe in detail its proposed approach for each of the required tasks listed in Section 3 and technical proposal requirements in Section 4 including any staff, systems, procedures, or materials that will be used to perform these tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

The proposed DM program outlined in this RFP will initially be voluntary ("opt-in") for program participants; however, the Department will be pursuing federal approval to change the DM program into a mandatory, or "opt-out" model. Any technical contract modifications will be made at the time federal approval is received to operate a mandatory DM program. Offerors that respond to the RFP need to discuss in their proposal how they plan to address transitioning from a voluntary to a mandatory program.

Note: DMAS welcomes new and innovative approaches to DM program services. While fully addressing the DMPA objectives on Pages 8-9 of this RFP, the Offeror may also include alternate approaches for DMAS consideration.

7.10.4 Chapter Four: Staffing

The proposal shall describe the following:

1. Staffing Plan: The Offeror shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this contract and relationships of the staff to each function of the organization. The staffing plan shall indicate the number of proposed FTEs by position and an estimate of hours to be committed to the project by each staff position. The plan shall also show the number of staff to be employed by the Contractor and staff to be obtained through subcontracting arrangements. Contact information must be provided for all key staff involved in the implementation and ongoing management of the program.

Offerors must submit 2 references for each proposed key staff member, showing work for previous participants who have received similar services to those proposed by the Offeror for this contract. Each reference must include the name of the contact person, address, telephone number and description of services provided.

2. Staff Qualifications and Résumés: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they will fill.

3. Office Location: A description of the geographical location of the central business office, the billing office, the call center and satellite offices, if applicable, shall be included. In addition, the hours of operation should be noted for each office as applicable to this contract.

7.10.6 Chapter Six: Project Work Plan

The proposal shall describe the following:

Work Plan and Project Management: The proposal shall include a work plan (Microsoft Project 2000 or compatible version) detailing the sequence of events and the time required to implement this project no later than October 17, 2005. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the project timetable from beginning to end shall be included in the proposal. Key dates and key events relative to the project shall be clearly described on the chart including critical path of tasks. The Offeror shall describe its management approach and how its proposed work plan will be executed.

Progress Reports: Upon award of a contract, the Contractor must prepare a written progress report every two weeks or more frequently as necessary and present this report to the Director, Division of Policy and Research or his designee. The report must include:

1. Status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project.
2. Target dates for completion of remaining or upcoming tasks/activities.
3. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays.
4. Any revisions to the overall work schedule.

7.11 RFP Schedule of Events

The following RFP Schedule of Events represents the State's maximum timeframe that shall be followed for implementation of the program.

EVENT	DATE
State Issues RFP	May 25, 2005

Deadline for Written Comments	June 8, 2005
State Issues Responses to Written Comments	June 13, 2005
Deadline for Submitting a Proposal to the Department	June 27, 2005
Intent to Award	September 5, 2005
Contract Signed and Approved	September 19, 2005
Readiness Review Begins (Information Systems, QI Program, Enrollee Services and other program components)	October 17, 2005
Implementation Date	December 1, 2005

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued to all Offerors by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The RFP and subsequent information will be listed on the Department's website (www.dmas.virginia.gov).

8. PROPOSAL EVALUATIONS AND AWARD CRITERIA

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the DMAS Director.

8.1 Evaluation of Minimum Requirements

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall deem the proposal non-responsive and subject to disqualification without further consideration. DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet: This form shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 7.8, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Section 7.

Mandatory Conditions: All mandatory General and Specific Terms and Conditions contained in Sections 9 and 10 shall be accepted.

8.2 Proposal Evaluation Criteria

The broad criteria for evaluating proposals includes, but is not limited to, the elements below:

1. Experience

   Describe the experience of the Offeror in performing DM services.
   - Experience of the Offeror in working with indigent populations, particularly Medicaid and FAMIS, or other healthcare populations.
   - Experience of the Offeror in performing services within the past year(s) most comparable to the Offeror's proposal, to include a description of the type, size, and duration of previous experience.

2. Technical Proposal

   Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.
   - Clarity and thoroughness of the Offeror's proposal in addressing the components of the RFP and implementing them as described and on schedule.
   - Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP

3. Staffing

   Describe the experience and expertise of specific staff assigned to the contract.
   - Prior experience of staff with similar projects.
   - Qualifications of staff.
   - Appropriateness of the relationship between staff qualifications and assigned responsibilities.

4. Quality of references
   - References who clearly address the nature of the work performed by the Offeror.
   - References who exhibit satisfaction with the work performed by the Offeror.
   - Contacts for other contracts who exhibit satisfaction with the work performed by the Offeror.

5. Proposed Savings Methodology

   The cost proposal shall be evaluated taking into consideration:
   - The factors used by the Offeror for the per member per month cost proposal as identified in Attachment IX.
   - The projected reductions in health care expenditures and net savings for DM participants and how the Offeror will achieve the reductions and net savings by the end of each State fiscal year.

6. Cost
   - The per member, per month (PMPM) cost proposal as identified in Attachment IX. The proposal must include PMPM costs for the voluntary and mandatory DM program models.

For purposes of evaluation each Offeror's PMPM cost by program category shall be multiplied by the average monthly enrollment for each enrollee category. The cost proposal shall be evaluated but is not the sole deciding factor for the RFP.

DMAS will not provide information to the Offerors on the specific weight of each these evaluation criteria until the date the proposals are due.

8.3 Award

The Department reserves the right to make multiple awards as a result of this solicitation issue one or more awards as a result of this RFP. DMAS shall select the best Offeror that, in its opinion, has the best proposal and shall award the contract(s) to that Offeror.

9. GENERAL TERMS AND CONDITIONS

9.1 VENDORS MANUAL:

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.state.va.us/dps under "Manuals."

9.2 APPLICABLE LAWS AND COURTS:

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

9.3 ANTI-DISCRIMINATION:

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every contract over $10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

a) The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor will include the provisions of 9.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

9.4 ETHICS IN PUBLIC CONTRACTING:
By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

9.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986:
By submitting their proposals, Offerors certify that they do not and will not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

9.6 DEBARMENT STATUS: By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

9.7 ANTITRUST:
By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

9.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS

Failure to submit a proposal on the official state form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

9.9 CLARIFICATION OF TERMS:

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Ms. Karen Lawson no later than June 27, 2005. Any revisions to the solicitation will be made only by addendum issued by the buyer.

9.10 PAYMENT:

1. To Prime Contractor:

   a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
   b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
   c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
   d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
   e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia,* § 2.2-4363).

2. To Subcontractors:

   a. A Contractor awarded a contract under this solicitation is hereby obligated:

(1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

(2) To notify the agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

9.11 PRECEDENCE OF TERMS:

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

9.12 QUALIFICATIONS OF OFFERORS:

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

9.13 TESTING AND INSPECTION:

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

9.14 ASSIGNMENT OF CONTRACT: A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

9.15 CHANGES TO THE CONTRACT: Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

   a. By mutual agreement between the parties in writing; or

   ii. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or

   iii. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

9.16 DEFAULT:

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and

administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

9.17 INSURANCE:

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractors will maintain these insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: $100,000.
3. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)

9.18 ANNOUNCEMENT OF AWARD: Upon the award or the announcement of the decision to award a contract over $50,000, as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA web site (www.eva.state.va.us) for a minimum of 10 days.

9.19 DRUG-FREE WORKPLACE:

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "*drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

9.20 NONDISCRIMINATION OF CONTRACTORS:

A Bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

9.21 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION:

The eVA Internet electronic procurement solution, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

1. eVA Basic Vendor Registration Service: $25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, and electronic bidding.
2. eVA Premium Vendor Registration Service: $200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. The eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research historical procurement data, as they become available.

10. SPECIAL TERMS AND CONDITIONS

10.1 Access To Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel

conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

10.2 Access To And Retention Of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

10.2.1 Access to Records

The Department, its duly authorized representatives and State and Federal auditors shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

10.3 Advertising

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to DMAS will be used in product literature or advertising without prior written permission from DMAS. The Contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services without prior written permission from DMAS.

10.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

10.5 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

10.6 Award

AWARD TO MULTIPLE OFFERORS: Selection shall be made of one or more Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price. Negotiations shall be conducted with the Offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror(s) that, in its opinion, has made the best proposal, and shall award the contract to that Offeror(s). The Commonwealth reserves the right to make multiple awards as a result of this solicitation. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia,* § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated

10.7 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

10.7.1 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than thirty (30) days prior written notice, which notice shall specify the effective date of the termination,
b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

10.7.2 Termination for Convenience

The Contractor may terminate this Contract with or without cause, upon six (6) full calendar months written notice to the Department. In addition, the Contractor may terminate the Contract by opting out of the renewal clause.

10.7.3 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

10.7.4 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

10.7.5 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If

the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid or FAMIS enrollees, DMAS may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

10.8 Remedies For Violation, Breach, Or Non-Performance Of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

10.8.1 Procedure For Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

10.8.2 Remedies Available To The Department

The Department reserves the right to employ, at the Department's sole discretion, remedies and sanctions to include payment withholds liquidated damages, and/or termination of the contract.

10.9 Performance Bonds

The Contractor shall deliver to DMAS executed performance bonds, each in the sum of four months of the estimated annual contract amount, with DMAS as obligee. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by DMAS.

10.10 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of at least 60-90 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 6.

Each invoice submitted by the Contractor shall be subject to DMAS approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by DMAS.

10.11 Identification of Proposal Envelope

The signed proposal should be returned in a separate envelope or package sealed and identified as follows:

From:_____ _____

Name of Offeror Due Date /Time

_____ _____

Street or Box Number City, State, Zip Code

_____

RFP Number

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

10.12 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

10.13 Minority/Women Owned Businesses Subcontracting and Reporting

Where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the Contractor is encouraged to offer such business to certified minority and/or women-owned businesses. Names of firms may be available from the Department of Minority Business Enterprise at www.dmbe.virginia.gov. When such business has been subcontracted to these firms and quarterly during the contract period, the Contractor agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted and type of product/service provided on a quarterly basis.

10.14 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

10.15 Renewal of Contract

This contract may be renewed by the Commonwealth upon written agreement of both parties for two successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

10.16 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

10.17 HIPAA Compliance

The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to DMAS. The Contractor will also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with DMAS to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the DMAS Internet Site at http://www.dmas.virginia.gov/hpa-home.htm.

10.18 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

10.19 Independent Contractor

Any Contractor awarded a contract under this RFP will be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

10.20 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

10.21 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to DMAS. DMAS must be notified within 10 days of any change in ownership. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

ATTACHMENT I – HOME AND COMMUNITY-BASED WAIVER SERVICES PROGRAM DESCRIPTION

Virginia provides a variety of services under home- and community-based waivers to specifically targeted individuals, which include but are not limited to personal care. Each waiver provides specialized services to help individuals in the targeted waiver population to reside in their communities. The five waivers available are:

- Elderly or Disabled with Consumer Direction (EDCD) Waiver - provides care in the community rather than in a nursing facility for disabled and elderly individuals who meet the level of care criteria and are determined to be at risk of nursing facility placement and for whom community-based care services under the Waiver is the critical service that enables the individual to remain at home rather than being placed in a nursing facility. Individuals must be mentally alert and have no cognitive impairments nor have an appointed guardian if they want to direct their own care, but may have someone else direct their care if they are not able. Approximately 10,161 individuals received services in the Elderly & Disabled Waiver and 417 individuals received services in the CDPAS Waiver during Fiscal Year 2004. These two waivers were combined to create the EDCD Waiver in February 2005.

- HIV/AIDS Waiver - provides care in the community rather than in a hospital or nursing facility for individuals who are experiencing medical and functional symptoms associated with HIV/AIDS. Approximately 274 individuals received services in the AIDS Waiver during Fiscal Year 2004.

- Individual and Family Developmental Disabilities (DD) Support Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of mental retardation who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify); (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in an ICF/MR. Approximately 270 individuals received services in the DD Waiver during Fiscal Year 2004.

- Mental Retardation (MR) Waiver - provides care in the community rather than in an Intermediate Care Facility for the Mental Retarded (ICF/MR) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation. Approximately 5,622 individuals received services in the MR Waiver during Fiscal Year 2004.

- Technology Assisted (Tech) Waiver - provides care in the community rather than in a nursing facility or hospital for individuals who are dependent upon technological support and require substantial, ongoing nursing care. Approximately 339 individuals received services in the Tech Waiver during Fiscal Year 2004.

ATTACHMENT II – MANAGED CARE COVERAGE MAP AND MCO CHARACTERISTICS

Figure II-A: Managed Care Coverage Area Map, Effective May 2003

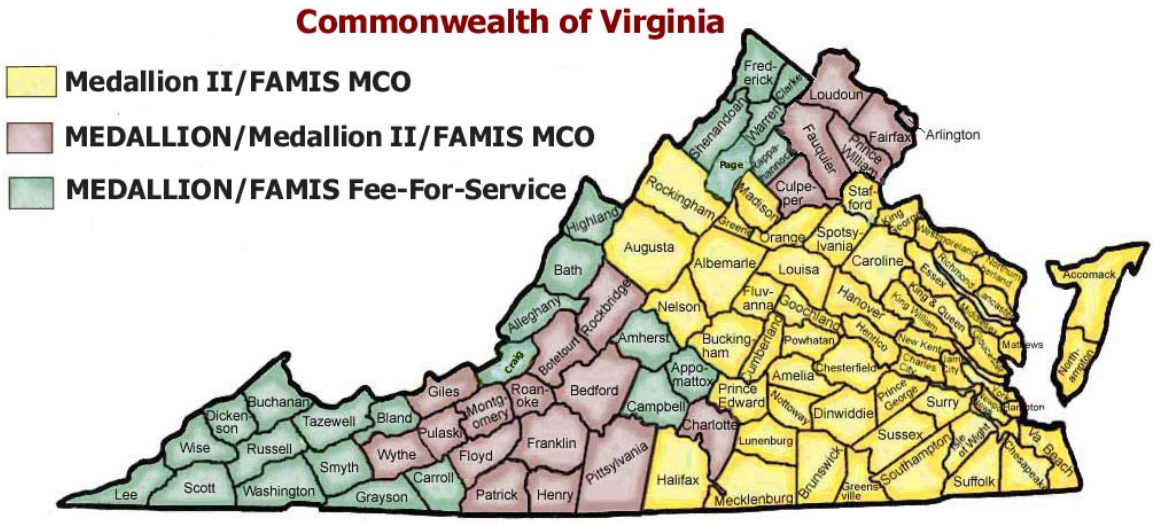


Figure II –B: MCO Characteristics

Health Plan	Alternate Address and Web Address	Enrollees as of July 2004	Localities and Medallion II Start Date	Accreditation
Anthem Healthkeepers, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	33,265	37 cities /counties Tidewater Central Virginia Regions Start Date: 01/01/1999	NCQA- Excellent Accreditation Status
Anthem Peninsula Health Care, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	17,389	16 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
Anthem Priority Health Care, Inc. Address: 2220 Edward Holland Drive Richmond, VA 23230	277 Bendix Road, Suite 100 Virginia Beach, VA 23452 Telephone: 1-800-901-0020 Website: http://www.anthem.com/	22,683	9 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
CareNet-Administered by Southern Health Address: 9881 Mayland Drive Richmond, VA 23233 Telephone: 804-747-3700	Website: http://www.southernhealth.com	14,335	30 cities/counties Tidewater and Central Virginia Regions Start Date: 01/01/1999	NCQA-Commendable Accreditation Status
Optima Family Care- Administered by Optima Health Plan Address: 4417 Corporation Lane Virginia Beach, Virginia 23462 Telephone: 1-800-SENTARA	Website: http://www.optimahealth.com	98,134	69 cities/counties Tidewater, Central Virginia, Charlottesville, and Halifax Regions Start Date: 01/01/1996	NCQA- Excellent Accreditation Status
UNICARE Health Plan of Virginia Address: 241 South Van Dorn Street Alexandria, VA 22304 Telephone: 1-800-997-4765	Website: http://www.unicare.com/	34,202	19 cities/counties Northern Virginia and Charlottesville Regions Start Date: 12/01/2001	NCQA Health New Plan
Virginia Premier Health Plan Address: 600 E. Broad Street, Ste 400 Richmond, VA 23219-1800	213 S. Jefferson Street, Ste 1400 Roanoke, VA 24011 Telephone: 804-819-5151 Website: N/A	64,673	73 cities/counties Tidewater, Central Virginia, Charlottesville, and Roanoke Regions Start Date: 01/01/1996	JCAHO

ATTACHMENT III – 2005-2006 APPROPRIATION ACT LANGUAGE

Item 326 #AAAA

"The Director of the Department of Planning and Budget is authorized to transfer amounts, as needed, from the Medical Assistance Services program (program 45600) to the Administrative and Support Services program (program 47900) to find administrative expenditures associated with contracts between the Department of Medical Assistance Services and companies providing disease state and chronic care management programs services for Medicaid recipients. The Department shall report on its efforts to contract for and implement disease state management programs in the Medicaid program by November 15, 2005, to the Chairmen of the House Appropriations and Senate Finance Committees and the Joint Commission on Health Care. The Department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act."

ATTACHMENT IV - POTENTIAL NUMBER OF MEDICAID AND FAMIS ENROLLEES WITH SPECIFIC CHRONIC CONDITIONS

Calendar Year 2004 Data	At Least One Condition	Two or more conditions	Asthma	CAD	CHF	Diabetes
MONTHLY INFORMATION – Unduplicated Eligibles						
January-04	38,654	8,778	23,026	3,342	2,605	8,101
February-04	38,858	8,871	23,276	3,369	2,615	8,096
March-04	39,494	9,023	23,774	3,407	2,645	8,129
April-04	40,045	9,175	24,158	3,504	2,705	8,206
May-04	40,162	9,291	24,308	3,516	2,738	8,215
June-04	40,270	9,373	24,418	3,515	2,749	8,252
July-04	40,203	9,490	24,334	3,571	2,781	8,287
August-04	39,872	9,586	24,058	3,587	2,784	8,302
September-04	39,707	9,643	23,936	3,617	2,783	8,288
October-04	40,067	9,836	24,134	3,680	2,850	8,384
November-04	40,226	9,923	24,287	3,713	2,849	8,431
December-04	40,438	9,968	24,542	3,742	2,860	8,403
Average Monthly	39,833	9,413	24,021	3,547	2,747	8,258
Total Member Months	477,996	112,957	288,251	42,563	32,964	99,094
ANNUAL INFORMATION						
Unduplicated Eligibles	54,511	12,682	32,935	4,905	3,958	11,233
Condition Only			28,199	646	556	3,407
Condition Plus Comorbidities			4,736	4,259	3,402	7,816
By Region						
Region 1	14,649	3,898	8,565	1,440	893	3,123
Region 2	8,060	1,876	4,882	734	518	1,752
Region 3	899	190	636	87	58	146
Region 4	4,004	774	2,681	188	212	713
Region 5	13,294	2,734	7,841	1,021	1,220	2,854
Region 6	11,066	2,732	6,590	1,216	927	2,201
Region 7	2,539	478	1,740	219	130	434
By Age Group						
<19	26,025	552	24,418	59	167	1,011
19-64	24,634	10,027	7,943	3,804	3,033	8,792
65+	3,852	2,103	574	1,042	758	1,420
Average Expenditures Per Recipient						
Condition			$ 5,552	$ 17,248	$ 24,422	$ 14,150
Condition Only			$ 3,836	$ 8,955	$ 21,416	$ 8,920
Condition Plus Comorbidity			$ 15,772	$ 18,506	$ 24,914	$ 16,430

Definitions:

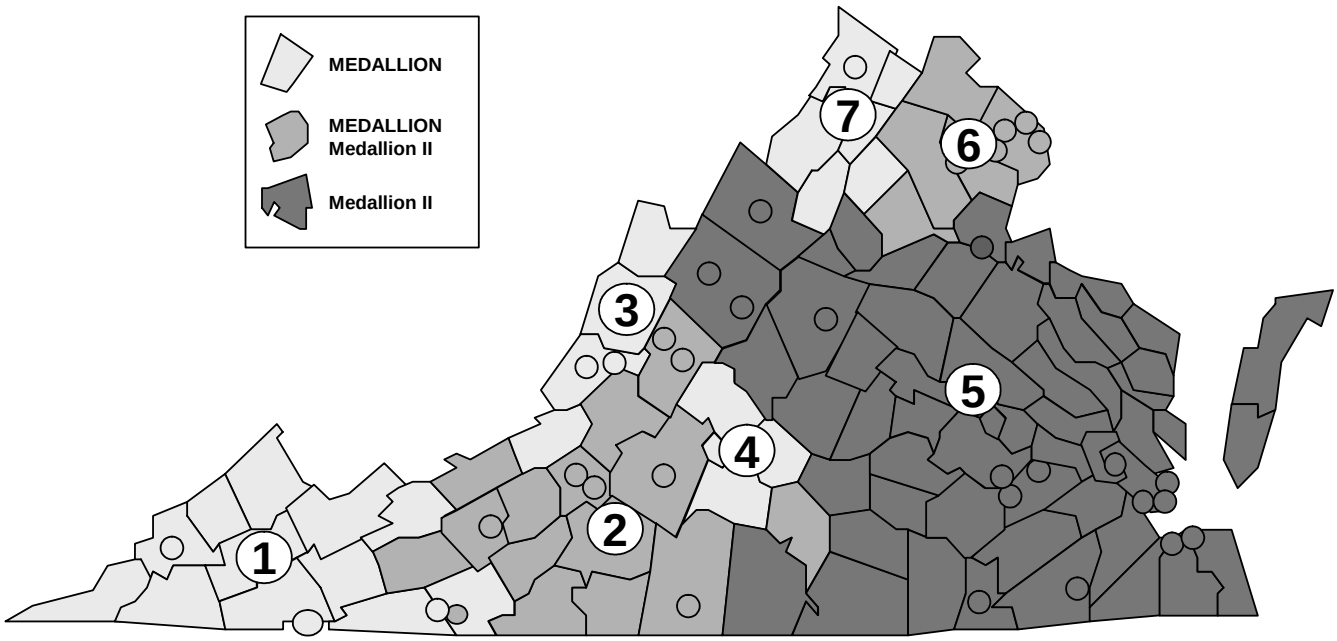
Unduplicated Eligible: Number of unduplicated persons in the month/year 1) who were eligible for Medicaid or FAMIS, 3) who were not excluded from the DSM program (persons who are in managed care, have third party liability insurance, are enrolled in Medicare, or are in an institution are excluded), and 3) for whom DMAS had received a claim with a primary or secondary diagnosis of the condition in the previous or current month/year based on a review of claims paid between January 2001 and December 2004.

Comorbidities: Indication that a person has more than one of the five targeted conditions

Region: Managed care regions as identified on the map in Appendix V.

ATTACHMENT V – VIRGINIA MANAGED CARE REGIONS

Virginia Managed Care Regions



ATTACHMENT VI - LIQUIDATED DAMAGES AND SANCTIONS

The Department may impose sanctions upon reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the RFP, provided, however, that the Department only impose those sanctions it determines to be appropriate for the deficiencies identified.

ATTACHMENT VII - HEALTH STATUS OUTCOMES AND QUALITY VARIABLES FOR CERTAIN DISEASE STATES

Tables V-A through V-D contain all quarterly quality variable reporting requirements. Each variable must be included in the reports, and each report must be trended from the previous quarter. These variables and the levels to be achieved will be negotiated during the contract period.

Table V-D contains the quality variables and levels to be achieved for the entire population. These variables and levels to be achieved are non-negotiable.

Table VII-A

A. Clinical Outcome Measures for Coronary Artery Disease (CAD)
Variables to be Measured
Percent of participants post-MI taking beta-blockers
Percent of all participants taking an aspirin or antiplatelet drug.
Percent of participants with a CAD diagnosis who had fasting lipid panel assessed within the measurement year per ATP-III.
Percent of participants with LDL screening performed on or between 60 and 365 days after discharge for an acute cardiovascular event.
Percent of non-diabetic participants who had Fasting Blood Glucose assessed annually.
Percent of all participants who received a flu vaccination within the last 12 months.
Percent of all participants who have ever received a pneumococcal vaccine.
Hospital admissions for MI within the measurement period
Percent of all participants who had a depression screening
Percent of participants with BP < 130/85.

Table VII-B

B. Clinical Outcome Measures for Congestive Heart Failure (CHF)
Variables to be Measured
The percent of participants taking aspirin, other antiplatelet medication or anticoagulant
Percent of all CHF participants who received a flu vaccination within the last 12 months
Percent of all CHF participants who have ever received a pneumococcal vaccine.
Participant Education Percent of CHF participants who comply with daily weights Percent of CHF participants who comply with sodium restriction Percent of CHF participants who comply with medication regimen Percent of CHF participants who have a rescue plan in place
Percent of CHF participants readmitted to the hospital with a primary diagnosis of heart failure within 30 days of hospital discharge for heart failure
Rate of emergency department visits with heart failure primary diagnosis or for pulmonary edema
Rate of hospital admissions for CHF
Percent of all CHF participants who had a depression screening

Table VII-C

C. Clinical Outcome Measures for Diabetes
Variables to be Measured
Percent of diabetes participants with a cholesterol test in the past year
Percent of diabetes participants with BP <130/80.
Percent of participants with diabetes who had one dilated retinal exam in the measurement year.
Percent of participants with diabetes who had one microalbumin screening test in the measurement year or receiving treatment for existing nephropathy
Percent of participants with diabetes who had at least two A1C tests in the measurement year.
Percent of diabetes participants >30 years of age taking an aspirin each day.
Percent of all diabetes participants who received a flu vaccination within the last 12 months.
Percent of all diabetes participants who have ever received a pneumococcal vaccine.
Percent of all diabetes participants who had a depression screening.

Table VII-D

D. Clinical Outcome Measures for Asthma
Variables to be Measured
Rate of hospital admissions for asthma
Percent of all asthma participants who received a flu vaccination within the last 12 months.
Percent of participants with spirometry testing within the past 12 months.
Percent of asthma participants with an emergency department admission for asthma in the past 12 months.
Percent of asthma participants with personal action plan for managing their asthma.

ATTACHMENT VIII – HEDIS® 2005 MEASURES

HEDIS 2005 Measures
Effectiveness of Care
Controlling High Blood Pressure
Beta-Blocker Treatment After a Heart Attack
Persistence of Beta-Blocker Treatment After a Heart Attack
Cholesterol Management After Acute Cardiovascular Event
Comprehensive Diabetes Care
Use of Appropriate Medications for People with Asthma
Access/Availability of Care
Adult's Access to Preventative/Ambulatory Health Services
Satisfaction With the Experience of Care
CAHPS® 3.0H Adult Survey
Use of Service
Inpatient Utilization – General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization – Nonacute Care
Outpatient Drug Utilization

ATTACHMENT IX
COST PROPOSAL: OFFEROR'S COST DETAILS FOR PRICING
(Reference RFP Section 6.2)

Proposed net savings in the overall health care expenditure costs (including disease management fees) in the eligible population(s).

Proposed Net Savings _____

Projected Per Member, Per Month Costs – Voluntary "Opt-In" Program

PMPM Costs	Per Member Per Month (PMPM) Cost	Price of Contract Year One	Price of Contract Year Two	Price of Contract Year Three	Total Price for Three Year Contract Period
Medicaid					
FAMIS					
Grand Total					

Projected Per Member, Per Month Costs – Mandatory "Opt-Out" Program

PMPM Costs	Per Member Per Month (PMPM) Cost	Price of Contract Year One	Price of Contract Year Two	Price of Contract Year Three	Total Price for Three Year Contract Period
Medicaid					
FAMIS					
Grand Total					

ATTACHMENT X - REFERENCES

RFP 2005-06

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of enrollees eligible, # of participants served, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	